STATEMEN	RS FOR MEDICAR IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUIL	JLTIPLE CONSTRUCTION DING	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED		
·		09G193	B. WIN	G			
NAME OF	PROVIDER OR SUPPLIEF			OTDEET ADDRESS ASSESSMENT	05/03/2010		
WESTV	EW 02		!	STREET ADDRESS, CITY, STATE, ZIP CODI 74 W ST, NW WASHINGTON, DC 20015	E		
(X4) ID PREFIX	SUMMARY S	TATEMENT OF DEFICIENCIES	ID.	PROVIDER'S PLAN OF CORR	FOTION	-	
TAG	REGULATORY OR	CY MUST BE PRECEDED BY FULL LSC (DENTIFYING (NFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	Haiin be	COMPLETION DATE	
W 000	INITIAL COMMEN	NTS	Wo	00			
W 102	clients was selected three men and two disabilities. The firm on observations, it in the home, as we administrative receincident/investigate. The outcome of the facility was not income a control of clients.	e survey determined that the compliance with the Condition of ent Protections and Health evidenced in the report that	W 10		TH STRATION 2ND FLOOR		
	The facility must end body and manager	nsure that specific governing ment requirements are met.		As of 5/14/10 a new governing body—Ma Homes, Inc. assumed receivership of this Westview facility.		5/14/10	
	review, the governi	is not met as evidenced by: ion, interview and record ng body failed to maintain direction over the facility. [See			İ		
№ 104	adequately govern ensure client protect care services. [See 483.410(a)(1) GOV	e systemic practices revealed verning body failed to the facility in a manner to ction [See W122]; and health W318]. ERNING BODY must exercise general policy,	W 104	See W102			
	Julia I	I lowson	ı UKİÇ	TITLE	7 1	X6) DATE	
		nn asterisk (*) denotes a deficiency which tection to the patients. (See instructions.)		tion may be excused from correcting proving nursing homes, the findings stated abovemes, the above findings and plans of correction are cited, an approved plan of correction			

Event (D: BO9C11

Facility ID: 09G193

If continuation sheet Page 1 of 41

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:	(X2) MULTI	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		A. BUILDIN	<u> </u>	COMPLE	:IED
	09G193	B. WING		05/0	3/2010
ROVIDER OR SUPPLIER		7.	4 'W' ST, NW	1 000	9/2010
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHO	ULD BE	(X5) COMPLETION DATE
•	-	W 104			
Based on observation review the governing deneral operating devidenced by the detection of the desired process of	on, interview and record g body failed to maintain lrection over the facility as eficiencies cited throughout				
1. The Governing b implement policies	ody failed to establish and/or to ensure the clients' health				
3. The governing be preventive health so in accordance with W331]	ody failed to ensure ervices and nursing services clients' needs. [See W322 and	W 122			
The facility must en	sure that specific client	 	The New governing body has structured training sessions to	ŗ	
Based on interview failed to promptly no members/legal gual origin and allegation to implement policie ensured clients' hea failed to ensure that and all allegations of W153]; failed to ensure that	and record review, the facility of the client's family rdians of an injury of unknown as of abuse [See W148]; failed as and procedures that allth and safety [See W149]; an injury of unknown origin of abuse were reported [See Bure that allegations of abuse		address deficiencies in terms of individuals protection.	_	6/10/10
	ROVIDER OR SUPPLIER SUMMARY STA (EACH DEFICIENCY REGULATORY OR LE Continued From pa budget, and operating Based on observatire view the governing of evidenced by the dethis report and the firm of the findings included. The Governing of the firm of the findings included. The Governing of the firm of the findings included. The Governing of the firm of the findings included. The findings included. The Governing of the findings included. The findings included. The facility included in accordance with the way. The facility must emprotections requirer. This CONDITION is Based on interview failed to promptly not members/legal gual origin and allegations of the failed to ensure that and all allegations of the way. The facility must emprotections requirer that and all allegations of the failed to ensure that and all allegations of the way.	DENTIFICATION NUMBER: 09G193 ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 1 budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on observation, interview and record review the governing body failed to maintain general operating direction over the facility as evidenced by the deficiencies cited throughout this report and the following: The findings include: 1. The Governing body failed to establish and/or implement policies to ensure the clients' health and safety. [See W149] 3. The governing body failed to ensure preventive health services and nursing services in accordance with clients' needs. [See W322 and W331]	ROVIDER OR SUPPLIER EW 02 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LISC IDENTIFYING INFORMATION) Continued From page 1 budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on observation, interview and record review the governing body failed to maintain general operating direction over the facility as evidenced by the deficiencies cited throughout this report and the following: The findings include: 1. The Governing body failed to establish and/or implement policies to ensure the clients' health and safety. [See W149] 3. The governing body failed to ensure preventive health services and nursing services in accordance with clients' needs. [See W322 and W331] 483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. This CONDITION is not met as evidenced by: Based on interview and record review, the facility failed to promptly notify the client's family members/legal guardians of an injury of unknown origin and allegations of abuse [See W148]; failed to implement policies and procedures that ensured clients' health and safety [See W149]; failed to ensure that an injury of unknown origin and all allegations of abuse were reported [See W153]; failed to ensure that allegations of abuse were reported [See W153]; failed to ensure that allegations of abuse were reported [See W153]; failed to ensure that allegations of abuse [See W153]; failed to ensure that allegations of abuse were reported [See W153]; failed to ensure that allegations of abuse [See W153]; failed to ensure that allegations of abuse were reported [See W153]; failed to ensure that allegations of abuse [See W153]; failed to ensure that allegations of abuse [See W153]; failed to ensure that allegations of abuse [See W153]; failed to ensure that allegations of abuse [See W153]; failed to ensure that allegations of abuse [See W153]; failed to ensure that allegations of abuse [See W153]; failed to ensure th	ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 1 budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on observation, interview and record review the governing body failed to ensure that specific client protections requirements are met. The Governing body failed to establish and/or implement policies to ensure that specific client protections requirements are met. This CONDITION is not met as evidenced by: Based on interview and record review, the facility as evidenced by the deficiencies cited throughout this report and the following: The findings include: 1. The governing body failed to ensure preventive health services and nursing services in accordance with clients' needs. [See W322 and W331] 483.420 CLIENT PROTECTIONS This CONDITION is not met as evidenced by: Based on interview and record review, the facility failed to promptly notify the clients's family members/legal guardians of an injury of unknown origin and allegations of abuse [See W148]; failed to implement policies and procedures that ensured clients' health and safety [See W148]; failed to ensure that allegations of abuse (See W148); failed to ensure that allegations of abuse were reported [See W1515]; failed to ensure that allegations of abuse were reported [See W1515]; failed to ensure that allegations of abuse see with allegations of abuse is seed to the seed of the seed o	ROWIDER OR SUPPUER SUMMARY STATEMENT OF DESICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) This STANDARD is not met as evidenced by: Based on observation, interview and record review the governing body failed to ensure the clients' health and safety. [See W149] 3. The governing body failed to establish and/or implement policies to ensure that specific client protections requirements are met. W 122 This CONDITION is not met as evidenced by: Based on interview and record review the governing body failed to ensure that specific client protections requirements are met. W 122 The facility must ensure that specific client protections requirements are met. W 122 The CONDITION is not met as evidenced by: Based on interview and record review, the facility failed to ensure the clients' health and safety. [See W149] 3. The governing body failed to establish and/or implement policies to ensure that specific client protections requirements are met. W 122 The New governing body has structured training sessions to address deficiencies in terms of individuals protection. This CONDITION is not met as evidenced by: Based on interview and record review, the facility failed to ensure that an injury of unknown origin and all elagations of abuse [See W149]; failed to ensure that an ensure that an injury of unknown origin and all allegations of abuse were reported [See W149]; failed to ensure that allegations of abuse were reported [See W149]; failed to ensure that allegations of abuse were reported [See W148]; failed to ensure that allegations of abuse were reported [See W148]; failed to ensure that allegations of abuse were reported [See W148]; failed to ensure that allegations of abuse were reported [See W148]; failed to ensure that allegations of a buse were reported [See W148]; failed to ensure that allegations of a buse were reported [See W148]; failed to ensure the allegations of a buse were reported [See W148]; failed to ensure that allegations of a buse were report

DEPAR	TMENT OF HEALTH	AND HUMAN SERVICES				PRINTED	: 05/20/2010
CENTE	<u>RS FOR MEDICARE</u>	& MEDICAID SERVICES					APPROVED 0. 0938-0391
AND PLAN (T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) I A. BU		TIPLE CONSTRUCTION	(X3) DATE S	URVEY
		09G193	B. WI	NG			
NAME OF F	ROVIDER OR SUPPLIER			J _s .	TREET ADDRESS, CITY, STATE, ZIP CODE	05/0	3/2010
WESTVI	EW 02			ı	74 W ST, NW WASHINGTON, DC 20015		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC	FIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPLICATION OF THE APPLICATI	III D DE	(X5) COMPLETION DATE
	abuse was investigate report the results of administrator or desfive working days of the effects of these in the failure of the ensure their health a 483.420(c)(6) COM CLIENTS, PARENT The facility must not parents or guardian changes in the client limited to, serious ill or unauthorized abs	that clients were protected all abuse while an allegation of ated [See W155]; and failed to all investigations to the signated representative within the incident [See W156]. It is systemic practices resulted facility to protect its clients and and safety. MUNICATION WITH S & tify promptly the client's of any significant incidents, or it's condition including, but not ness, accident, death, abuse, ence.	W		2		
	members/legal guar origin and allegation clients residing in the The findings include On 4/29/10, at approvith direct care staff both had legal guard their habilitation and later in an Interview at approximately 8:2	dians of an injury of unknown of abuse for two of five e facility. (Clients #1 and #2) eximately 5:05 p.m., interview revealed Clients #1 and #2 lians that were involved in care. This was confirmed with the residential manager of p.m. on the same day.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUIL	JLTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED	
		09G193	B. WIN	G		F10310040
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 74 'W' ST, NW WASHINGTON, DC 20015		5/03/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG		N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
W 148	approximately 1:40 failed to provide evilegal guardians and made aware of the - An incident/investi revealed that Client his neck was bothe - An incident report corresponding investi/1/10/09, revealed Client #1 reported to put his hands down - An incident report corresponding investallegation of verbal/came into the qualif professional's (QMF "counselor" told him off the van. - An unusual incider corresponding investional incider corresponding investigation court. Client	p.m., revealed the facility idence that Clients #1 and #2's l/pr family members were following incidents: igation report dated 2/8/10, #1 complained to staff that ring him. dated 11/8/09, and stigation report dated an allegation of sexual abuse. It is pants. dated 9/26/09, and stigation report, revealed an physical abuse. Client #2 ided mental retardation RP's) office and stated that a into shut up" and pushed him intreport dated 10/2/09, and stigation report dated an allegation of verbal abuse. It #2 kept raising his hand to illowed him to speak, and the	W 1	48		
W 149	provide evidence that family members of (aware of the aforem 483.420(d)(1) STAF CLIENTS	F TREATMENT OF	W 14	As per receivershi agreement MarJul	<u>. </u>	5/14/10
	The facility must dev policies and procedu	/elop and implement written ures that prohibit		has been effective 5/14/10		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SLIPPO INFORMATION IN THE PROVIDER/SLIPPO IN THE PROVIDER IN TH					FORIN): 05/20/2010 APPROVED	
STATEMEN.	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IULTIPL ILDING	E CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED	
_	·	09G193	B. WI	NG			
NAME OF P	ROVIDER OR SUPPLIER		_1	CTOF		05/0	03/2010
WESTVI	EW 02	_		74 '	ET ADDRESS, CITY, STATE, ZIP CODE W ST, NW ASHINGTON, DC 20015		
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREF TAG	ıx	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	CHIDRE	(X5) COMPLETION DATE
W 149	Continued From pa	ge 4	14/	140			<u> </u>
		ect or abuse of the client.	VV	149			
·	failed to establish a ensure the health a	s not met as evidenced by: and record review, the facility nd/or implement policies to nd safety of three of five ne facility. (Clients #1, #2 and					
!	The findings include	e:					
:	1. The facility failed to ensure the Department of Health (DOH) was notified timely of significant incidents (allegations of abuse and one injury of unknown origin) in accordance with federal regulations and state law.	notified timely of significant is of abuse and one injury of accordance with federal					
	5/3/10, revealed evi- abuse, and one inju- documented to have and 2/2010. Contin- incident reports faile	3. Review of the facility's gation reports on 4/30/10 and dence of three incidents of ry of unknown origin that were e occurred between 9/2009 ued review of the facility's ad to show evidence that the th (DOH) was informed the dents timely.					
	quained mental reta were conducted on a p.m., respectively. I who witnessed, disc the aforementioned immediately docume incident report form, The RN and the QM have been notified o	esident manager (RM) and ordation professional (QMRP) 5/3/10, at 4:00 p.m., and 7:20 They both indicated that staff overed or were informed of incidents should have ented the incidents on an before the end of the shift. RP stated that DOH should fall allegations of abuse and origin immediately followed.					

CENTER	RS FOR MEDICAR	E & MEDICAID SERVICES					FORM APPROVED OMB NO. 0938-0391			
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI		PLE CONSTRUCTION G		(X3) DATE S COMPLE	URVEY		
		09G193	B. WIN	IG_		_	0.510	2/2040		
NAME OF P	ROVIDER OR SUPPLIER EW 02			7	REET ADDRESS, CITY, STATE, 4 W-ST, NW VASHINGTON, DC 20015		05/03/2010 DDE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG		PROVIDER'S PLAN (EACH CORRECTIVE / CROSS-REFERENCED T DEFICIE	CTION SHO	KULD RE	(X5) COMPLETION DATE
W 149	Review of the faci policy (IMP) on 5/1 p.m., revealed that into both reportable incidents. Allegatinjuries of unknown serious reportable policy, staff were the case manager or guardian for all incident report for serious reportable report was to be followed to	dity's incident management 3/10, at approximately 6:00 at incidents were categorized le and serious reportable ions of abuse, neglect and resource were identified as a incidents. According to the required to "immediately call" required to "immediately call" required to "immediately call" required to the completed on "all incidents" and the incidents are were to be completed on "all incidents" and the incident convarded to the DOH within 24 the facility's incident report, at that the facility had not ad the State agency of incidents, and the State agency of incidents, and the develop written policies for an englect, mistreatment, and for ren origin. 53. Review of the facility's ion reports on 4/30/10 and widence of three incidents of ury of unknown source. There are ed evidence that the facility's been notified of these incidents iew of the facility's "incident icy on 5/3/10 revealed the verbal and written are client's case manager. DOH	W 1	49						
<u> </u> 	and the client's par however, failed to	rent or guardian. The policy, indicate that the administrator as specified by federal						}		

PRINTED: 05/20/2010 FORM APPROVED

SINICMEN	TOF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	T-4#: -:			M APPROVE D. 0938-039	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	TIPLE CONSTRUCTION VG	(X3) DATE	(X3) DATE SURVEY COMPLETED	
		09G193	B. WING _				
NAME OF	PROVIDER OR SUPPLIER				05/	03/2010	
WESTY	EW 02		311	REET ADDRESS, CITY, STATE, ZIP C '4 W' ST, NW	ODE	•	
(X4) ID	Clusses			WASHINGTON, DC 20015			
PRÉFIX TAG	REGULATORY OR L	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
W 149	Continued From pa	ige 6	W 149				
	the notification of a	V148. The facility failed to nent its written policy regarding uardians and/or family s reportable incidents as	** 143	·			
	both had legal guar their habilitation and later in an interview at approximately 6:: Review of the facility corresponding investigation and investigation and informed of all significations and injuries of unknown revealed that a land injuries of unknown reportable in the client's parent or reportable incidents.	y's incident management 10, at approximately 6:00 allegations of abuse, neglect own source were identified as acidents. Further review of ataff were required to e case manager, DOH, and quardian for ell serious					
a	abuse while an inves	failed to prevent further tigation was in progress in rincident management					

CENTER	RS FOR MEDICARI	& MEDICAID SERVICES				. 0938-0391		
	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		09G193	B. WING		- OE!!	12/2040		
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 74 "W" ST, NW WASHINGTON, DC 20015					
(X4) ID PREFIX TAG	1 (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION DATE		
W 149	corresponding investigation at 6:52 when staff was not schedule, while the Review of the incidence of 5/3/10, at approximagency will provide violations are those prevent the potent investigation is in unknown origin and reviewed by the action of the review of four corresponding investigation at 6:52 of the investigation within	unusual incidents and estigative reports on 4/30/10, c.m., revealed one incident tremoved timely from the envestigation was in progress. Ident management policy on nately 7:00 p.m., revealed the evidence that all alleged bughly investigated and must it is for further abuse while the progress. W156. The facility failed to evestigations of injuries of diallegations of abuse were diministrator within five working the with their incident ey. unusual incidents and estigative reports on 4/30/10, p.m., revealed results of three his had not been reported to the in five working days.	W 149					
	5/3/10, at approximate results of all investagency's incident four days for reviet that it reaches the administration and disability agency with the rooted, how	dent management policy on mately 7:00 p.m., revealed the tigations will be reported to the management coordinator within w and approval, and ensure health regulatory I the local developmental within five working days. It was ever, that this policy did not of the administrator.						
	6. Cross-Refer to ensure the effective "Medication Mana"	W322. The facility failed to re implementation of it policy on gement."						

PRINTED: 05/20/2010 FORM APPROVED

AND PLAN	T OF DEFICIENCIES OF CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/SIA IDENTIFICATION NUMBER:	F	ULTIPLE LDING	CONSTRUCTION	FORM APEROVE OMB NO. 1938-039 (X3) DATE SURVEY COMPLETED		
·	·	09G193	B. WII	NG				
NAME OF F	ROVIDER OR SUPPLIER					05/	03/2010	
WESTVI	EW 02			74 W	ADDRESS, CITY, STATE, ZIP CODE ST, NW	E		
(X4) ID PREFIX TAG	YOUR DEFICIENTY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL 3C IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF	10411 0 00	(X5) COMPLETION DATE	
W 149	Continued From pa	ge 8	W1	149	DEFICIENCY			
W 153	effectiveness of a pi The review of the fa Management policy, Monitoring (dated 1/ revealed, "All medic physician." Interview record review on 4/3 the effectiveness of constipation, (Consti ml by mouth daily), a Magnesia, 1 ounce t evening) had not bee physician. 483.420(d)(2) STAFI CLIENTS The facility must ens mistreatment, neglecinjuries of unknown s	section IV(a), Medication 08) on 5/3/10, at 11:07 a.m. ations shall be monitored by a with the nursing staff and the 0/10 and 5/3/10 revealed that medications prescribed for ulose10 gm/15 ml syrup, 30 as needed and Milk of by mouth as needed in the en closely monitored by the FTREATMENT OF	1	53	See W149 Above	•		
; ;	THE BUILDING TO THE 20	Iministrator or to other						
-	This STANDARD is Based on interview a and investigations, that allegations of negligings of unknown of mediately to the addepartment of Health icensing Administrations.	not met as evidenced by: nd review of incident reports e facility failed to ensure that						

If continuation sheet Page 9 of 41

DEPART	MENT OF HEALTH	AND HUMAN SERVICES				FORM	05/20/2010 APPROVED
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		AULTIF	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		09G193	B. WI	NG		OSIO	3/2010
NAME OF P	ROVIDER OR SUPPLIER		<u></u>	STR	EET ADDRESS, CITY, STATE, ZIP CODE	1 00/0	3/2010
WESTVIE	EW 02			74	W ST, NW /ASHINGTON, DC 20015		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREI TA	FIX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE	(X5) COMPLETION DATE
W 153	Continued From pa	ge 9	w	153	,		-
15	The findings include	- :	**	1004			
	corresponding invebeginning at 6:52 p 1. An incident repordated 2/8/10, reveato staff that his necessive to staff that his necessive was called at the client to the embransportation van. with a primary diagricular review of the nurse and hous informed of the injury of the injury of unknown of documented evider administrator was informed evider administrator was in the control of the injury of unknown of the injury of	ty's incident reports and stigative reports on 4/30/10, .m., revealed the following: .m., revealed the following: .m. to (injury of unknown origin) alled that Client #1 complained k was bothering him. The not instructed the staff to escort ergency room via the		The second secon			
	corresponding investigation and investigation until 11/1 allegation was madinistrator was approximately 12:13 administrator was not investigation until 11/1 allegation was madinistrator was not investigation until 12:13 administrator was not investigation until 12:15 administrator was not investigation until 13:15 administrator was not investigation until 14:15 administrator was not investigation.	rt dated 11/8/09, and stigation report dated an allegation of sexual abuse of satisficial that another staff had his pants. The nurse for any signs of abuse, e incident report revealed that as not informed of this 0/09, two days after the e. Interview with the previous ent Coordinator on 5/3/10, at 5 p.m., acknowledged that the ot notified immediately of the abuse until two (2) days later.					

CENT	ERS FOR MEDICAR	E & MEDICAID SERVICES			PRINTE	D: 05/20/2010 MAPPROVED
IJIMIEME	NI UH DHEKNEMCICO	(X1) PROVIDER/SUPPLIER/CLIA	T		OMB N	O. 0938-0391
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CONSTRUCTION LDING	(X3) DATE	
		09G193	B. WIN	IG .	-	
NAME DE	PROVIDER OR SUPPLIER				05/	03/2010
WEST	/IEW 02			STREET ADDRESS, CITY, STATE, ZIF 74 W ST, NW	CODE	
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	<u> </u>	WASHINGTON, DC 20015		
PRÉFIX	REGULATORY OR	T MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG		FION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
VV 153	Continued From p	age 10	W 1			
	allegation of verba came into the QMF "counselor" told hir off the van. The ni any signs of abuse report revealed that informed of this alle QMRP on 4/30/10, acknowledged that	port dated 9/26/09, and estigation report, revealed an I/physical abuse. Client #2 RP's office and stated that a m to shut up "and pushed him urse examined the client for . Further review of the incident the administrator was not egation. Interview with the at approximately 7:30 p.m., the administrator was not y of the allegation of abuse.				
	While in court, Clies speak. The Judge a client stated "staff y review of the incide administrator was n	ort dated 10/2/09, and stigation report dated an allegation of verbal abuse. In #2 kept raising his hand to allowed him to speak, and the vas hollering at him". Further ont report revealed that the lot informed of this allegation.				
W 154	administrator was n allegation of verbal 483.420(d)(3) STAF	p.m., acknowledged that the ot notified immediately of the	184 45			
	CLIENTS	The state of the s	W 15	4		i 1
	The facility must have violations are thorou	ve evidence that all alleged ighly investigated.		In addition to 15 MarJul Homes w	/ill be	
, , ,	failed to thoroughly i	not met as evidenced by: and record review, the facility restigate all injuries of or Incidents of abuse, for two siding in the facility. (Clients		required to follow DDS/DOH policy regarding staff tree of individuals.	y ;	
RM CMS-25	87/02-89) Previous Versions	riving in the racility. (Clients			, 	

CENTE	RS FOR MEDICAR	E & MEDICAID SERVICES		•	FORM	1 APPROVED). 0938-0391
STATEMENT	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI	ILTIPLE CONSTRUCTION DING	(X3) DATE S	SURVEY
		09G193	B. WING	3	081	03/2010
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP (J3/2010
WESTVI	EW 02		٠. ا	74 W ST, NW WASHINGTON, OC 20015		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
W 154	Continued From page 11 #1 and #2)		W 1	54		İ
	! . The findings includ	de:			-	
	incident reports ar mental retardation	ning at 6:52 p.m., review of the nd interview with the qualified professional (QMRP) revealed unknown origin and abuse must estigated.				
	On 5/3/10, at approximately 1:40 p.m., continued review of the incident/investigation reports revealed the following injury of unknown origin and abuse:	ent/investigation reports				
	corresponding inverse alled that on 2 staff about his necessaled and instruct to the emergency	V153.1. Review of the estigation report dated 2/15/10, /8/10 Client #1 complained to tk bothering him. The nurse was ted the staff to escort the client room via the transportation van. charged with a primary ain neck".				
	Further review of t	he agency's internal aled the following:				
	a. The investigatio and/or a written sta completed the inci	n falled to include an interview atement from the staff that dent report.				
	b. The investigatio with Client #1 to as have occurred to h	n failed to include an interview scertain how the injury may lis neck.				
	follow-up up with h	n failed to identify a date of is primary care physician, as 9/10, hospital discharge				

PRINTED: 05/20/2010

FORM APPROVED

PTATEMEN	TO TOK MEDICARE	& MEDICAID SERVICES			•		MAPPROVED	
AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI	ULTIPL	E CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY		
	ž	DENTIFICATION NUMBER:	A. BUII		•	COMP	SURVEY LETED	
		09G193	B. WIN	lG.		-		
NAME OF F	PROVIDER OR SUPPLIER	033133				05/	03/2010	
WESTVI				74'	ET ADDRESS, CITY, STATE, ZIP CODE W ST, NW		3472010	
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES		WA	SHINGTON, DC 20015			
PREFIX	REGULATORY OR L	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI) TAG	ĸ	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)		(X5) COMPLETION DATE	
W 154	Continued From pa	ge 12	W 1	54		<u></u>	_	
,	d. The investigation and/or written stated time the incident was	failed to document interviews ments from staff on duty at the is reported.						
:	e. The investigation causes of the injury	failed to show other possible						
į	p.m., acknowledged	revious incident Management 10, at approximately 1:50 I that she had not thoroughly 1's injury of unknown origin mine it's cause.						
	corresponding investigation in the corresponding investigation in the corresponding investigation in the corresponding investigation in the corresponding investigation in the corresponding in the co	tigation report completed on hat Client #1 stated that down my pants. The r (RM), nurse, and QMRP nurse examined the client for The police were collected.						
į '		include the following:						
1,	a. An interview and/o staff that allegedly pu pants.	r written statement from the it his hands down Client #1's						
i '	b. An interview and/o shift leader to whom reported.	r written statement from the the allegation was initially						
	. Falled to determine	on what date the nurse		İ		ļ		

W 154 Continued From page 13 assessed the client for any signs of abuse. Reportedly, the nurse was notified on 11/10/10, two days later. d. Failed to include the date on which Client #1 was evaluated medically after the allegation of sexual abuse. e. Failed to include an interview with Client #1 regarding the allegation of sexual abuse allegation was not thoroughly investigated. 3. On 5/3/10, at approximately 2:30 p.m., review of the corresponding investigation report completed on 10/8/09, revealed that on 10/7/09, "I [Incident Management Coordinator] was informed by a counselor that Client #2 hit client #1 in the head with a large pencil. Client #1 hit filent #1 in the head with a large pencil. Client #1 hit filent #1 in the head with a large pencil. Client #1 hit filent #1 in the head with a large pencil. Client #1 hit hit in the head with a large pencil. Client #1 hit filent #1 in the head with a large pencil. Client #1 hit hit in the head with a large pencil. Client #1 hit hit in the head with a large pencil. Client #1 hit hit in the head with a large pencil. Client #1 hit hit in the head with a large pencil. Client #1 hit hit in the head with a large pencil. Client #1 hit hit in the head with a large pencil. Client #2 hit client #3 hit not complain of pain. He ate dinner and applied triple antibiotic ointment to the a rea. Client #1 did not complain of pain. He ate dinner and went to bed. Further review of the agency's internal investigation revealed the following: a. The investigation failed to include an interview and/or written statement from the staff that completed the unusual incident report. b. The investigation failed to include interviews		OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
WESTVIEW 02 SUMMARY STATEMENT OF DEFICIENCES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REDULATORY OR LSC IDENTIFYING INFORMATION) W 154 Continued From page 13 assessed the client for any signs of abuse. Reportedly, the nurse was notified on 11/10/10, two days later. d. Failed to include the date on which Client #1 regarding the allegation of sexual abuse. Interview with CMRP on 5/3/10, at approximately 7.00 p.m., acknowledged that the sexual abuse allegation was not thoroughly investigated. 3. On 5/3/10, at approximately 2:30 p.m., review of the corresponding investigation report completed on 10/8/09, revealed that on 107/7/09, "I [Incident Management Coordinator] was informed by a counselor that Client #2 like Client #1 in the head with a large pencil. Client #1 had a small scratch on the middle part of his head." The RM, QMRP, and nurse were notified. The nurse assessed the wound, cleaned the area, and applied triple antibiotic ointrement to the area. Client #1 did not complain of pain. He ate dinner and want to bed. Further review of the agency's internal investigation revealed the following: a. The investigation failed to include an interview and/or written statement from the staff that completed the unusual incident report. b. The investigation failed to include interviews			09G193	B. WING		05/0	3/2010		
PREFIX TAG REQUATORY OR LSC IDENTIFYING INFORMATION) W 154 Continued From page 13 assessed the client for any signs of abuse. Reportedly, the nurse was notified on 11/10/10, two days later. d. Failed to include the date on which Client #1 regarding the allegation of sexual abuse. Interview with QMRP on 5/3/10, at approximately 7:00 p.m., acknowledged that the sexual abuse. Interview with QMRP on 5/3/10, at approximately 7:00 p.m., acknowledged that the sexual abuse allegation was not thoroughly investigated. 3. On 5/3/10, at approximately 2:30 p.m., review of the corresponding investigation report completed on 10/8/09, revealed that on 10/7/09, "I [Incident Management Coordinator] was informed by a counselor that Client #1 had a small scratch on the middle part of his head." The RM, QMRP, and nurse were notified. The nurse assessed the wound, cleaned the area, and applied triple antibiotic ointment to the area. Client #1 hid and to complain of pain. He ate dinner and went to bed. Further review of the agency's internal investigation revealed the following: a. The Investigation failed to include an interview and/or written statement from the staff that completed the unusual incident report b. The investigation failed to include an interview and/or written statement from the staff that completed the unusual incident report b. The investigation failed to include interviews					74	4 'W' ST, NW			
assessed the client for any signs of abuse. Reportedly, the nurse was notified on 11/10/10, two days later. d. Failed to include the date on which Client #1 was evaluated medically after the allegation of sexual abuse. e. Failed to include an interview with Client #1 regarding the allegation of sexual abuse. Interview with QMRP on 5/3/10, at approximately 7:00 p.m., acknowledged that the sexual abuse allegation was not thoroughly investigated. 3. On 5/3/10, at approximately 2:30 p.m., review of the corresponding investigation report completed on 10/8/09, revealed that on 10/7/09, "I [Incident Management Coordinator] was informed by a counselor that Client #1 in the head with a large pencil. Client #1 in the head with a large pencil. Client #1 in the head with a large pencil. Client #1 had a small scratch on the middle part of his head." The RM, QMRP, and nurse were notified. The nurse assessed the wound, cleaned the area, and applied triple antibiotic ointment to the area. Client #1 did not complain of pain. He ate dinner and went to bed. Further review of the agency's internal investigation revealed the following: a. The investigation failed to include an interview and/or written statement from the staff that completed the unusual incident report. b. The investigation failed to include interviews	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API	OULD BE	COMPLETION	
and/or written statements from two other staff who witnessed the incident.	W 154	assessed the client Reportedly, the nurtwo days later. d. Failed to include was evaluated med sexual abuse. e. Failed to include regarding the allegation was not to the corresponding the corresponding the corresponding the corresponding the corresponding to make the corresponding to make the corresponding to the correspo	for any signs of abuse. se was notified on 11/10/10, the date on which Client #1 lically after the allegation of an interview with Client #1 ation of sexual abuse. P pn 5/3/10, at approximately edged that the sexual abuse horoughly investigated. proximately 2:30 p.m., review g investigation report 09, revealed that on 10/7/09, "I ent Coordinator] was informed Client #2 hit Client #1 in the encil. Client #1 had a small dle part of his head." The RM, were notified. The nurse id, cleaned the area, and obtic ointment to the area. Implain of pain. He ate dinner he agency's internal ed the following: I failed to include an interview ment from the staff that sual incident report. I failed to include interviews ments from two other staff	W	154				

STATEME	ERS FOR MEDICAR	H AND HUMAN SERVICES E & MEDICAID SERVICES			FORI	D: 05/20/20 M APPROVE D. 0938-039
AND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	PLE CONSTRUCTION	(X3) DATE COMPI	SURVEY
		09G193	B. WING		1	
NAME OF	PROVIDER OR SUPPLIER		erpe	ET ADDRESS OF	05/	03/2010
WESTV	7EW 02		74	EET ADDRESS, CITY, STATE, ZIP CODE "W" ST, NW ASHINGTON, DC 20015		
(X4) ID PREFIX	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID I	**************************************	·	
TAG	ALSOLATORY OR	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	HIDBE	(X5) COMPLETIO DATE
W 154	T TOTAL PE	age 14	W 154			+
	c. The investigation with Clients #1 and incident had occurr	n failed to include an interview #2 to determine why the red.	VV 154			
	Interview with QMRP on 5/3/10, at approximately 7:10 p.m., acknowledged that the client to client abuse was not thoroughly investigated.					<u> </u>
W 155	revealed "Staff and the incident" should the survey, there we ensured that relevan	acility's policy on investigations 10, at approximately 2:00 p.m., others knowledgeable about be included. At the time of as no evidence the facility had nt details were obtained from ding the aforementioned re thorough investigations. FF TREATMENT OF	W 155			
İ	The facility must pre while the investigation	event further potential abuse on is in progress.		See W145 Above		
	failed to provide evide protected from further allegation of abuse v	and record review, the facility dence that clients were er potential abuse while an was investigated, for one of ing in the facility. (Client #2)				
-	The finding includes:	· 1				
j j	5/3/10, revealed an in 9/26/09. According to	Review of the incident ations on 4/30/10, and on an ancident/investigation dated the investigation report, Client of toid him to "shut up" and a van.				
M CMS-25A	7(02-99) Previous Versions O					
	· · · · · · · · · · · · · · · · · · ·	Disolete Event ID: ROpc:11	F . 100 s			

Event ID: BO9C11

Facility ID: 09G193

If continuation sheet Page 15 of 41

DEPARTMENT OF HEALTH AND HUMAN SERVICES

	ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIP	i com		TE SURVEY MPLETED	
		09G193	B. WING	· · · · · · · · · · · · · · · · · · ·	05/0	3/201 0	
NAME OF P	ROVIDER OR SUPPLIER EW 02		74	ET ADDRESS, CITY, STATE, ZIP CODE "W" ST, NW ASHINGTON, DC 20015			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
W 155	Interview with the Ir Coordinator (IMC) at the investigation repaperoximately 12:3 [IMC] received a caretardation professive allegation of abuse QMRP informed mainto her office and shut up and pushed a written statement alleged staff. Accordid not push Client touched him. I never shut up. I had never behavior support plafter the alleged incraving about what with the QMRP observe should go to work at the next day (9/27/0 p.m., to 11:00 p.m. staff was removed pending allegation through a formal left mailed to the alleged IMC and the QMRP the alleged perpetrayork the next day a being removed from Review of the facilities.	ncident Management and the continued review of port on 5/3/10, at 0 p.m., revealed that "she all from the qualified mental ional (QMRP) regarding an that occurred on 9/26/09. The a [IMC] that Client #2 came stated that staff told him to d him out the van." The investigation report included dated 10/2/09 from the rding to the statement, "I [staff] #2 off the van. I never are told Client #2 to be quiet or are been trained on Client #2's an. On Sunday 9/27/09 (day cident), Client #2 was still was wrong and cussing, and d this and said I [alleged staff] at the other facility." The IMC later that day alleged staff did return to work 09) and completed his 3:00 shift. The IMC stated that from client contact due to of abuse. This was verified iter dated 9/28/09, that was ad staff's home. Although the owere informed of the incident, ator was allowed to return to and complete her shift, prior to in the schedule.	W 155				
	however, revealed	approximately 6:00 p.m., employees who are alleged to					

DEPAR	TMENT OF HEALTH	AND HUMAN SERVICES			PRINTE	D: 05/20/20 10
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES	•		FORM	M APPROVED
ISIAIEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII	ULTIPLE CONSTRUCTION LDING	OMB NO. 0938-0391 (X3) OATE SURVEY COMPLETED	
		09G193	B. WIN	IG		
NAME OF	PROVIDER OR SUPPLIER		<u>· l</u>		05/	03/2010
WESTV	EW 02			STREET ADORESS, CITY, STATE, ZIP CODE 74 "W" ST, NW		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES		WASHINGTON, DC 20015		
PRÉFIX TAG	REGULATORY OR L	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	IO PREFII TAG	. I was a sure of the VC HOM Shall	JII D.BE	COMPLETION DATE
W 155	Continued From pa	ge 16	W 1			
	have committed and be immediately place reassigned to a nos	y form of abuse or neglect will ced on administrative leave or lition that does not allow any until the results of the	VV ,	55		
W 156	potential for prevent while an investigation	Irvey, there was no evidence emented its policy to the further abuse of it clients, on was being conducted. F TREATMENT OF	W 1:	56	·	
į	TO DIE SOMMUSCISCOL	restigations must be reported or designated representative n accordance with State law lays of the incident.		In addition to W153-W155 MarJul will folloagency protocol of incident notification.	ow	
	failed to ensure requof unknown origin ar reviewed by the admired	STANDARD is not met as evidenced by: d on interview and record review, the facility to ensure required investigations of injuries known origin and allegations of abuse were wed by the administrator within five working for two of five clients residing in the facility. ats #1 and #2)	See attachment #2			
	The findings include:					
	qualified mental retal and review of the factories on ding invest conducted on 4/30/10 and 5/3/10, at approximates the staff that his neck.	0, beginning at 6:52 p.m., kimately 1:40 p.m. The evealed Client #1 complained was bothering him. The	,			

STATEMENT OF AND PLAN OF CO		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N	IULTIPL	E CONSTRUCTION	(X3) DATE S	
VIAD LEVIA OL OC	ORRECTION .	IDENTIFICATION NUMBER:	A. BU	LDING		COMPLE	TED
		09G193	B. Wi	NG		05/0	3/2010
NAME OF PROV	AIDER OR SUPPLIER		·	74	ET ADDRESS, CITY, STATE, ZIP CODE W'ST, NW ASHINGTON, DC 20015		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
training records and all was continued and a	th a primary diagraview of the correvealed that the Incordinator (IMC) of the energy was no written energy and Questigation report and vestigation report and vestigation report and completed that Client ands down my partitle energy and Questigation report and presponding investigation was responding investigation was responding to the police were calculated the investigation was responding to the police were the proximately 3:15 westigation was responding investigation of verball kept raising his beautiful the police were the proximately 3:15 westigation of verball kept raising his beautiful the police were at him five days.	The client was discharged nosis of a "strain neck". Is sponding investigative report cident Management completed the investigation. In evidence that the results of the reviewed by the five days. In the corresponding completed on 11/10/09, if the stated that "staff" put his ints. The Residential Manager MRP were informed. The eclient for any signs of abuse. Ited and he was taken to a examination. Review of the stigative report revealed that ement Coordinator (IMC) stigation. There was no at the results of the eviewed by the administrator. In the court, Client in and to speak. The judge ask, and the client stated "staff"	W	156			

OTATELES.	TO FOR MEDICAR	E & MEDICAID SERVICES				MAPPROVED
AND PLAN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	IPLE CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED	
		09G193	B. WING			
NAME OF	PROVIDER OR SUPPLIER				05/	03/2010
WESTV			7	REET ADDRESS, CITY, STATE, ZIP CODE 4 "W" ST, NW VASHINGTON, DC 20015		
(X4) ID PREFIX TAG		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP	SULS SE	(X5) COMPLETION DATE
W 156	Continued From pa	age 18	W 156	DEFICIENCY)		
	IMC within four day ensure that it reach Management Unit of There is no mention review of the invest the IMC was assign 483.430(a) QUALIF RETARDATION PF Each client's active integrated, coordinated qualified mental retaint and the second second in the second se	treatment program must be ated and monitored by a ardation professional. Is not met as evidenced by: on, staff interview, and record ailed to ensure the Qualified Professional (QMRP) ted, and monitorad services, if the five clients residing in the 2, #3, #4 and #5) It P failed to ensure consistent ogress on the Individual objective for Clients #3 and it P failed to coordinate the prescribed diet of Client P failed to coordinate	W 159	Current QMRP will coordinate to ensure al IPP objectives are bein implemented and monitored. The QMRP will coordinate with the nutritionist to ensure the all individuals are following the diet and menu as prescribed by the nutritionist. The QMRP will coordinate with the psychologist and psychiatrist and nurse to ensure that quarterly all individuals quarterly drug regimen reviews are conducted.	e nat	6/10/10
	services to ensure q	uarterly drug regimen	 - 			

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. BUILDING		COMPL	6160
		09G193	B. WING	<u> </u>	05/0	3/2010
WESTVI	ROVIDER OR SUPPLIER		74'	ET ADDRESS, CITY, STATE, ZIP CODE W' ST, NW ISHINGTON, DC 20015		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
W 159	Continued From pa	ge 19	W 159			
	reviews were condi #5. [See W362]	ucted for Clients #3, #4, and				:
W 252	483.440(e)(1) PRO	GRAM DOCUMENTATION	W 252			į l
	; specified in client ir	complishment of the criteria ndividual program plan documented in measurable		See W159 Above.		
	Based on observation review, the facility for documentation of program Plan (IPP	s not met as evidenced by: ion, interview and record ailed to ensure consistent rogress on the Individual) objectives, for two of three le. (Clients #3 and #4)				
	The findings includ	e :				
	consistently mainta	ensure that data was ined on the training objectives e behavior of Clients #3 and elow:				
	approximately 6:19 talking to herself, a the left side of her liclient's medication implemented by the (LPN). The direct collent to the medical	client #4 on 4/29/10, at p.m., revealed she began is she repeatedly hit herself on head. During this time, the objective was being a licensed practical nurse care staff who escorted the ition room said, "happy face" I times, and she began to calm				
	i dated 8/17/09, on 4	's behavior support plan (BSP) /30/10 at 9:24 a.m., revealed self-injurious behavlors (SIB),				!

CENTE	RS FOR MEDICAR	& MEDICAID SERVICES		•	FORM	J. US/2U/2010 MAPPROVED
ISIAIEMEN	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	040) B.U. U		OMB NO	0.0938-0391
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVEY	
			A. BUILDING		COMPL	.ETED
		09G193	B. WING			
NAME OF	PROVIDER OR SUPPLIER				05/0	03/2010
WESTVI	EW 02		74 خ	EET ADDRESS, CITY, STATE, ZIP CODE "W' ST, NW		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES		ASHINGTON, DC 20015		
PREFIX TAG	REGULATORY OR L	V MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)		(X5) COMPLETION DATE
W 252	= = minuse tetti pe	ge 20	W 252			
	which included pun	Ching herself on face or head	VV 252			•
	According to Frequ	BDCV Of Targeted Behavior	1			İ İ
	Fulli, the face slab	DIDO/DUNChing behavior about it	1			i j
	ne accommented.	18 ABC Data Collection Shoot L				1
	interventions and -	ntecedents, behaviors,				i I
	be documented each	esponses to the intervention the time staff observe the client	J			1
	exhibit a targeted h	ehavior. Review of the	1			Ì
	i alcrementioned for	10 on 4/30/10 at 0⋅25 a	1			
i	revealed that the fa	Ce sianning observed by the	ľ			i l
į	341 YEYUF OH 4/29/10	Ouring the medicalian	' !			
	administration had r	not been documented.				!]
j	At the time of the su	rvey, there was no evidence				i 1
	the facility had ensu	red consistent data collection	1			
	to lacultate accollate	Monitoring of Client #4's				
-	progress in her beha	avioral objective.	!] [
!						! .
ĺ	administration on 46	ient #3 during the medication	I			
!	he slapped himself	29/10 at 7:26 p.m., revealed repeatedly on the right side of	ĺ			!
	his face, as soon as	the nurse assisted him to				i
- 1	sanitize his hands.	He then got up from the chair,	İ			
	consing loudly, and t	Medan "Buffing and blowings				
I	THE WIFE CARE STAIT	WITO ASCOrted the client to	ĺ			
	the medication room	asked the client to colon			: 	
	down, and continued	I to talk to him until 7:20 n m	!			•
1 1	Antomating, UR SDD8	I bae mise ed 01 0916			ļ	
['	accepted his medica	tions.			1	
: 	Interview with staff o	n 4/29/10 during the		•		
1.5	medication administr	ation revealed that the	1		i	1
; 1	naugaiors exhibited f	ov Client #3 were heine			ļ	
	addressed by his BS	p,			i	
1	Pavious of Oires un-	Pag			ļ	
	1/30/10 of Client #3's	BSP dated 4/19/10, on			j	- 1
· · · · · · · · · · · · · · · · · · ·	:hallenging behaute:	revealed the client exhibited	1		ļ	1
l i	ace stanning periorion	s which included screaming, eavy breathing. According to			1	1
		According to	İ			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A BUILDING			(X3) DATE SURVEY COMPLETED		
		09G193	B. WING	G	05/03/2010
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 74 W ST, NW WASHINGTON, DC 20015	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE COMPLETION
W 318	the Frequency of Tathe ABC Data Colles should be document the client exhibit at the aforementioned a.m., revealed that during the medicationly the heavy breawas documented on. There was no doc Collection Sheet cotargeted behavior. At the time of the sithe facility had ensut to facilitate accurate progress in his behavior as a facility must enservices requireme. This CONDITION is Based on interviews facility failed to ensist services were coordicatility's nursing services were coordicatility's nursing services were coordicated to the services were coordi	argeted Behavior Form and action Sheet, these behaviors atted each time staff observes targeted behavior. Review of a forms on 4/30/10 at 9:59 of the behaviors observed ion administration on 4/29/10, athing (puffing and blowing), athing (puffing and blowing), athing (puffing and blowing), athing (puffing and blowing), athing (puffing and blowing), athing (puffing and blowing), athing (puffing and blowing), athing (puffing and blowing), athing (puffing and blowing), athing (puffing and blowing), athing (puffing and consistent data collection are monitoring of Client #3's avioral objective. CARE SERVICES Insure that specific health care ents are met. It is not met as evidenced by: It is not met as evidence by: It is not met as evidence by: It is not met as evidence by: It is not met as evidence by: It is not met as evidence	W 2		ices 6/10/10
1	the demonstrated fa health care services 483.460(a)(3) PHYS	ailure of the facility to provide s.	W 32	22	

CENTE	NO FOR MEDICAR	E & MEDICAID SERVICES				M APPROVED
AND PLAN	T OF DEFICIENCIES DF CORRECTION	(X1) PRDVIDER/SUPPLIER/CLIA	(X2) MULTIS	PLE CONSTRUCTION		D. 0938-0391
		IDENTIFICATION NUMBER:	A BUILDING		(X3) DATE COMP	SURVEY LETED
	•		1			
NAME OF		09G193	B. WING		A	70.004 n
POWE OF	PROVIDER OR SUPPLIER		STR	EET ADDRESS, CITY, STATE, ZIP CODE	<u></u>	03/2010
WESTV	EW 02		74	W ST, NW		
			W	ASHINGTON, DC 20015		
(X4) ID PREFIX	SUMMARY ST. (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORP	ECTION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION &	HOLLIN DE	(X5) COMPLETION
	·	<u> </u>	""	CROSS-REFERENCED TO THE AP DEFICIENCY)	PROPRIATE	DATE
W 322	Continued From pa	age 22	144 000			
	! :		W 322	See W318		1
	The facility must pr	ovide or obtain preventive and	!			
	general medical ca	re.	1 1			
	1					!
			, ,			
	This STANDARD	in mak				ļ
	Based on observat	is not met as evidenced by: lon, interview, and record				1
	review the facility f	alled to ensure timely	[ı
ı	preventive health s	ervices for one of three clients				i
	in the sample. (Clie	ent #3)				
ļ		•				!
	The findings include	ə:				
	1 [Cross refer to M	(2042 The course of				ļ
·	ensure timely media	/331]. The facility failed to cal follow-up for Client #3 with	ļ			ì
	the primary care ph	ysician (PCP) after his	İ			
	emergency room vi	sits due to constipation.				i
		i	!			
!	Record review on 4	/30/10 at 6:35 p.m. revealed				ļ
İ	mar Olight #2 USD 8	Several hospitalizations for	ļ			1 1
ļ	AUDINITIES IN TARIL SOC	n and a total colostomy for a	1.			
j	Was reversed in No	98. Although the colostomy vember 2008, he continued to				i 1
ļ	have GI problems a	S evidenced below:				
1						i !
	a. On 4/30/10, at 10	:37 a.m., the review of an	ŀ			
:	unusual IIICIOENI FED	NOT (LUR) detect AIS/40				i !
ļ	(DCS) discourse d C	p.m., a direct care staff	i i			1
i	Crying He was taken	lient # 3 on the floor and				
ļ	(ER) for evaluation :	n to the emergency room	i			
í	-abdominal" and "co	and was diagnosed with "pain instipation -slow transit". The				[]
I '	August (Cranifical to Itle	EMPROPOV mom on Aleka 🕠	1 i		,	
1	ioi assessiiledi Oi A	Omiting Review of the En i				
1.	uisciiai ge summarv	dated 4/8/10 for the 4/5/40	!			
	AUTOL DAIRAGE TOTON	UD With the DCD in tunks			i	
1.	on days and to co	Office the FR " if there was a	ı I			
	problem arranging th	18 follow visit with the DCD A			:	ı

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
	09G193	B. WING		0.54	03/2010	
NAME OF PROVIDER OR SUPPLIER WESTVIEW 02		74	ET ADDRESS, CITY, STATE, ZIP (W' ST, NW ASHINGTON, DC 20015		33/2010	
PRÉFIX (EACH OFFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
p.m., revealed a con PCP dated 4/13/10 was evaluated in the the symptoms were however, made no how to monitor the was no evidence the within the recommed [Note: Client #3's signature of the continued to have he days, between 4/13 Documentation of 4/30/10, revealed in any stools for six disabdominal pain, the 4/30/10 and was disa	more fluids were 1/30/10, at approximately 6:10 consultation report from the to which stated that the client the ER for constipation and that the enow resolved. The PCP, specific recommendations on problem. Additionally, there that the client receive follow-up tended time frame. 1/30/10 and 4/24/10 and the client revealed he that stools.] every one to three 1/10 and 4/24/10. 1/30 stools between 4/24/10 and 1/30 evidence that the client had 1/30 and 4/24/10. 1/31 and 1/34/10 and 1/32 and 1/34/10 and 1/30 an	W 322				

CENTE	RS FOR MEDICAR TOF DEFICIENCIES	H AND HUMAN SERVICES E & MEDICAID SERVICES			FORM	D: 05/20/2010 MAPPROVED D: 0938-0391
AND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION ING	(X3) DATE (SURVEY
		09G193	B. WING			
NAME OF	PROVIDER OR SUPPLIER		S	FREET ADDRESS, CITY, STATE, ZIP (05/0	03/2010
WESTVI	EW 02			74 'W' ST, NW WASHINGTON, DC 20015	OUE	
(X4) ID PREFIX TAG	(EACH DEFICIEND	ATEMENT OF DEFICIENCIES IY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIVE CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
W 322	Continued From p	age 24	W 322			<u> </u>
	mg/10 ml by mouth physician's orders prescribed as a store Further record reviewed a current Constulose 10 gm/daily, as needed for orders revealed the prescribed on 10/2 and was subseque Review of the med 10/2009 revealed a "Lactulose 30 ml poconstipation."	29/10, at 7:28 p.m., Client #3 sodium 50 mg/5 ml, 100 n. The review of the 4/1/10 revealed the medication was sol softener at 6:00 p.m. daily, ew on 5/3/10 at 10:45 a.m., physician's order for 15 ml syrup, 30 ml by mouth r constipation. The physician's at the Constulose was initially 3/09 by the gastroenterologist ntly approved by the PCP ication administration for 10/23/2009 order for o dality as need for				
į	revealed that it coul when the client may Constulose other th interview with the R	an in 12/09. Continued N and the licensed practical ad that no Constudes				
	rredication administrevealed that MOM evening was listed a According to the 12/administered Constituted revening through 5/3 documentation that Constulose at any or	a.m., the review of the tration record (MAR) for 11/09 1 oz. PO as needed in the and not the Constulose. 12009 MAR, the client was alose in the evening on eieven iew of the MARs from 1/10, however, revealed no Client #3 was administered ther time. It should be noted then the administration of				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. BUILDING		COMPLET	ED [
		09G193	B. WING		05/03/	/2010
WESTVI	ROMDER OR SUPPLIER		74	EET ADDRESS, CITY, STATE, ZIP CODE "W' ST, NW ASHINGTON, DC 20015	.1	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE :	(X5) COMPLETION DATE
W 322	At the time of the s medical criteria had determine when to and/or the pm. Add evidence effective implemented to mir constipation. [See 3. The facility's medimely treatment for dental caries. [See	for hard stool) and 10/14/09 ed by staff). urvey, there was evidence d been established to administer the Constulose litionally, there was no preventive measures had been nimize Client #3's risk of also W460] dical services failed to ensure r Client #3 to address his W356]	W 322			
VV 331	The facility must pr services in accorda This STANDARD i Based on interview failed to ensure nur accordance with the	ovide clients with nursing ince with their needs. Is not met as evidenced by: and record review, the facility rsing services were provided in e needs of four of five clients ty. (Clients #2, #3, #4, and #5)	VV 331	MarJul Homes will follow nursing protocol for individuals; to include medications administered every othe day as needed.	r	6/10/10
	close monitoring ar measures to minim emergency room (E as evidenced below Interview with the re 8:49 a.m., revealed hospitalized severa survey. Interview w	sing services failed to ensure nd implementation of ize the frequency of Client #3's ER) visits due to constipation,				

CENTE	<u>RS FOR MEDICAR</u>	H AND HUMAN SERVICES E & MEDICAID SERVICES					FORM): 05/20/2010 APPROVED : 0938-0391
AND PLAN C	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUII		ONSTRUCTION		DATE S	BURVEY
·	·	09G193	B. WIN	G		1		
NAME OF P	ROVIDER OR SUPPLIER			erneer .		L_	05/0	3/2010
WESTVII				74 W :	DDRESS, CITY, STATE, ZIP CO ST, NW INGTON, DC 20015	DDE		
(X4) ID PREFIX TAG	LEACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF() TAG	- 	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	A BUONS I	ΩE	(X5) COMPLETION DATE
	movement within a informed, so that it medication for con also indicated that stool in 3 to 4 day, and instructions by be taken to the em assessment. Intervegistered nurse (F7:40 p.m., however seen a written polic should be taken to the exery one to three of 4/24/10. Document 4/24/10 and 4/30/10 are confirmed that any seem paint of abdomenting the ER on 4/30/10 are confirmed the following for his complaint of abdomenting that occurred for Clark (FER)" from Client (client did not have a bowel 2 to 3 days, the nurse was he client received his pm stipation. The home manager that if the client did not have a upon assessment by the nurse the physician, the client was to ergency room (ER) for riew with the recently hired RN) on 5/3/10 at approximately revealed that she had not ey stating when the client ER for constipation. however, that Client #3's stool e continued to have hard stool days, between 4/13/10 and tation of stools between 0, revealed no evidence that stools for six days. Due to a hinal pain, the client returned to and was diagnosed with eview on 4/30/10 and on 5/3/10 wing ER visits/ hospitalization lent #3: ation /Services Request K3's day program dated) revealed he was evaluated abdominal pain, holding his crying. Upon assessment the repeared very hard and at was reported as oriented x el sounds, BP 156/96, T97 ared to be constipated - sat a while pushed and	W3		DEFICIENCY			
ļg	proaned, but could r	not go. Please treat		i			1	

	OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING		(X3) DATE S COMPL			
		09G193	B. WING		05/0	3/2010
WESTVII	ROVIDER OR SUPPLIER EW 02		74	ET ADDRESS, CITY, STATE, ZIP "W' ST, NW ASHINGTON, DC 20015		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENCE	FION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
W 331	accordingly and moderate and upon notificating the client #3 was observed and upon notificating the client was escolved with construction. A CT scan of the above of an unsurand upon notificating the client was escolved with construction. A CT scan of the above of an unsurand upon notificating the client was escolved with construction. A CT scan of the above of an unsurand upon notificating the client was escolved with construction. A CT scan of the above of an unsurand upon notificating the client was escolved with construction. That it was most like final diagnosis was resolved with construction. The review of an unsurand upon notificating the client was escolved with construction. The review of an unsurand upon notificating the client was escolved with construction. That it was most like final diagnosis was resolved with construction. The review of an unsurand upon notificating the client was escolved with construction. The review of an unsurand upon notificating the client was escolved with construction. The review of an unsurand upon notificating the client was escolved with construction. The review of an unsurand upon notificating the client was escolved with construction. The review of an unsurand upon notificating the client was escolved with construction.	onitor closely. 5 p.m., the RN wrote a reply at t #3's aforementioned FER am. The note revealed, relief. Laxative given 3 hours	W 331			
	•	1	1			1

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 05/20/2010 CENTERS FOR MEDICARE & MEDICAID SERVICES **FORM APPROVED** STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION <u>OMB NO. 0938-0391</u> (X1) PRDVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY COMPLETED A BUILDING B. WING 09G193 NAME OF PROVIDER OR SUPPLIER 05/03/2010 STREET ADDRESS, CITY, STATE, ZIP CODE **WESTVIEW 02** 74 W ST, NW WASHINGTON, DC 20015 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) **PREFIX** TAG DATE DEFICIENCY) W 331 Continued From page 28 W 331 care staff (DCS) informed the nurse that Client #3 had not had a bowel movement since 12/4/09. On the next day (12/8/09) at approximately at 4:00 p.m., the LPN contacted the staff and stated that per the RN coordinator's instructions, the client should be taken to the ER, if he did not have a BM. Upon review of the client's record, it was was determined by the LPN an the Qualified Mental Retardation Professional (QMRP) that the client should be taken to the ER for evaluation. On 4/30/10 at approximately 7:10 p.m., review of Client #3's 12/9/09 ER discharge instructions revealed a primary diagnosis of pain-abdominal, generalized and a secondary diagnosis of Constipation - unspecified. Blood work, and an acute abdomen series and a CT of abdomen and pelvis w/ contrast were performed stat due to the client's complaint of abdominal pain. The client was discharged from the ER in satisfactory condition with a recommendation for follow-up by the primary care physician (PCP) in 1 - 2 days, without fail. c. On 4/30/10 at 10:37 a.m., the review of an unusual incident report (UIR) dated 4/5/10 revealed that at 9:15 p.m. a direct care staff (DCS) discovered Client #3 on the floor holding his side crying, and saying "I need to go to the hospital". According to the UIR, the supervisor was informed of the client's complaint, then telephoned the registered nurse. Further review of the UIR revealed the R.N. instructed staff to escort the client to the hospital. The client was diagnosed with and treated for constipation, and

then released to the group home. (Note: An RN progress noted dated 3/21/10 documented "poor water intake, B/M reportedly remain irregular. Will continue to monitor." The next RN entry, dated

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING			(X3) DATE SURVEY COMPLETED	
		09G193	B. WII	NG	1	05/	03/2010
WESTVI	PROVIDER OR SUPPLIER EW 02			74	ET ADDRESS, CITY, STATE, ZIP CODI W ST, NW ASHINGTON, DC 20015		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
W 331	4/3/10 reported "re no medical sign of d. On 4/30/10, at 4 dated 4/6/10 revea care staff observed entrance of the fact the client had vomit was notified immediate the client back further evaluation. e. On 4/30/10, at 1 was heard coming. The home manager saying that Client # The manager community with him. Up reason for the client discovered that the pain and said that By 10:42 a.m., the the client continued home manager was the client to the ER. Record review on 5 Client #3 was dischand that his primare 2. Cross Refer to V staff failed to coord care physician and determine the criter medication to preve evidenced below:	gular coaxing to drink water, issue reported." :45 p.m., the review of an UIR led that at 10:30 p.m., a direct of Client #3 standing at the main ility. The UIR documented that ited all over the area. The R.N. diately and instructed staff to octo the emergency room for 0:35 a.m., very loud yelling from the front of the facility. From the front of the facility er went to check, and returned item to check, and returned i	W	331			

75111L	TO FOR MEDICAR	E & MEDICAID SERVICES				M WALKOVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIDENTIFICATION N		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	TPLE CONSTRUCTION	(X3) DATE	<u>0. 0938-0391</u> Survey Leted
		09G193	B. WING_		i	
NAME OF	NAME OF PROVIDER OR SUPPLIER				05/	03/2010
WESTV	EW 02		. 7	REET ADDRESS, CITY, STATE, ZIP C '4 'W' ST, NW WASHINGTON, DC 20015	ODE	
(X4) ID PREFIX TAG		TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
ļ 	5/3/10 revealed C with regular bowel indicated that they the nurse if the clie three days. The sollent's stools were Review of the daily at approximately 1 confirmed the staff Interview with the approximately 7:40 was hired by the acknowledged that changes in the RN RN revealed that he client was to be (Constulose or Mill On 4/30/10 at 6:40 progress note date gastroenterologist hospitalized on 9/1 has had problems His diet was chang residue. The docus keep him regular. Ican take? Fluid inta Distress 6/7/09 and by prescribing Lacticonstipation pm andicated that the Glaxative to Client #3	movements. The staff had been instructed to inform ent did not have a BM in two to taff also reported that the electron of the did not have a BM in two to taff also reported that the electron of the did not have a BM in two to taff also reported that the electron of the did not have a BM in two to taff also reported that the electron of the did not be often large and hard stools. If statements. The electron of the 4/2010 at the electron of the facility. The electron of the facility. The electron of the facility. The electron of the facility. The electron of the facility of the electron of the facility. The electron of the facility of the electron of the facility of the electron of the facility. The electron of the facility of the electron of the facility of the electron	W 331	DEFICIENCY)	- ATT NOTRIALE	
	the need to follow c	reeducated verbally regarding losely. [The client's]		•	ļ	'

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY		
		DENTI IONNON NONDEN,	A. BUILDING		COMPLETED	
		09G193	B. WING		05/03/2010	
WESTVI	PROVIDER OR SUPPLIER	·	74	EET ADDRESS, CITY, STATE, ZIP CODE "W' ST, NW ASHINGTON, DC 20015		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLE	
W 331	Continued From pa	ge 31	W 331			
	elimination pattern s days), taking medic acknowledged the (assist in his GI issu	still erratic (every 3 days or 4 ations as directed. The nurse Gl's order for Lactulose pm to es and noted "Bowel every 3 - 4 days. Drs are				
	revealed the month and 12/09 documer	view on 5/3/10, at 11:07 a.m., ly nursing summaries for 1/09 lited an erratic stool pattem, g stools every three to four				
	notes dated 1/18/10 should receive the (review of the medic	nat although nursing progress), documented that Client #3 Constulose 30 ml daily pm, ation administration records ent had only received it during				
	nursing services had care physician and t	trvey, there was no evidence docordinated with the primary the gastroenterologist to ctions on when to administer for constipation.				
	4/29/10 at 7:40 p.m.	of the medication supply on and again on 7:50 p.m., ose was available at the				
	communicate Client constipation on the the when Client #3 v	ing staff failed to accurately #3 medication prescribed for consultation referral form to vas taken to the emergency n on 12/8/09 as evidenced				
	Review of a medical	consultation form dated	1		;	

CENTE	NO FOR MEDICARI	& MEDICAID SERVICES			CAME AIC	A YELKOAED
STATEMEN AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED	
	•	09G193	B. WING_			
NAME OF	PROVIDER OR SUPPLIER	090193	<u> </u>		05/	03/2010
WESTVI			7.	REET ADDRESS, CITY, STATE, ZIP CO 4 "W" ST, NW VASHINGTON, DC 20015	DOE	
(X4) ID PREFIX TAG	(EACH DELICIENC.	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	이 유민이에 가 많은	(X5) COMPLETION DATE
	12/7/09 which was revealed the purpor 3-4 days, decrease Lactulose BID and the physicians order written revealed that Docusate 100 mg at that the Lactulose/CFurther record reviet the client prescriber Lactulose twice dail 4. The facility failed medication was dobelow: Observation of the redication of the received Dilantin 50 The nurse was obset the section of the call interview with the numedication was punify revealed he did nevening dosage of the missing. Further interview when agency, approximate survey. According to medication was lost	written by the RN coordinator se of the consult as "No BM for d bowel sounds. Treatment Docusate BID." The review of crast the time the consult was at Client #3 was prescribed at 6:00 p.m. daily only and that Constulose, was prescribe prn. aw revealed no evidence that d or had received Docusate or by. to ensure lost/missing cumented as evidenced medication administration on revealed that Client #2 mg tab (3 tabs), 150 mgs. arded dated 4/30/10.	W 331	DEFICIENCY)		
į	5. [Cross Reference staff failed to ensure	W336] The facility's nursing quarterly medical ompleted in a timely manner.				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING		COMPLE	160
_		09G193	B. WING		05/0	3/2010
WESTVII	ROVIDER OR SUPPLIER		74	ET ADDRESS, CITY, STATE, ZIP CODE 'W' ST, NW ASHINGTON, DC 20015		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W 331	The quarterly nursing conducted timely for Interview with the fat 4/29/2010 at appropriate facility's nursing inconsistent and the unavailable for reviewas newly hired on diligently to correct services. 6. [Cross Reference nursing services fair pharmacist to ensureviews were conducted with the service of their health quarterly or more froblem to the service of three samp and #5] The findings include Record review on 4 revealed the most review on 4 re	acility's Registered Nurse on ximately 4:51 p.m. confirmed oversight and services were at some assessments were eat. She further indicated she 4/8/2010 and was working the problems with the nursing the problems with the nursing that quarterly drug regimen acted for Clients #3, #4, and URSING SERVICES ust include, for those clients ding a medical care plan, a this status which must be on a requent basis depending on some some action of quarterly reviews for olded clients. [Clients #3, #4, etc. /30/2010, at 6:35 p.m., recent nursing quarterly on file	W 331	All nursing services will be completed in a timel manner including follow up of all consultants recommendations as we as timely completion of all nursing quarterly assessments and nursing monthly notes.	y w- eil f	6/10/10
	facility's nursing se consistent impleme three of three samp and #5] The findings include Record review on 4 revealed the most re-	rvices failed to ensure ntation of quarterly reviews for pled clients. [Clients #3, #4, etc.] /30/2010, at 6:35 p.m., ecent nursing quarterly on file gned and dated 12/2009. On			g	

コース・コロマスト	IT OF DEFICIENCIES OF CORRECTION	E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATE	M APPROVI O. 0938-03 SURVEY
		09G193	A. BUILDII B. WING	NG	COMPLETED	
NAME OF	PROVIDER OR SUPPLIER				05/	03/2010
WESTV			1	REET ADORESS, CITY, STATE, ZIP COD 74 'W' ST, NW	E	
(X4) ID PREFIX TAG	I CAUT DEFICIENT	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI		(X5) COMPLETIO
W 356	respectively, recor recent nursing qua and #5 were signed in the same day a confirmed there were completed after 9/2 Continued Interview approximately 7:15 assessment was confirmed there were completed after 9/2 Continued Interview approximately 7:15 assessment was confirmed the time of the sensure the timely confirmed the timely confirmed the sensure the timely confirmed the sensure the timely confirmed the sensure the timely confirmed the sensure the timely confirmed the sensure the timely confirmed the sensure the timely confirmed the sensure the timely confirmed the sensure the timely confirmed the sensure the timely confirmed the sensure the timely confirmed the sensure the timely confirmed the sensure the timely confirmed the sensure the sensure that the	d review revealed the most arterlies on file for Clients #4 d and dated 9/2009. facility's registered nurse (RN) that approximately 2:50 p.m., are no quarterly assessments 2009 for Clients #4 and #5. When with the RN on 4/30/2010, at it p.m., confirmed no quarterly completed for Client #3 after urvey, the facility failed to completion of nursing quarterly sure the health and safety of #5. IPREHENSIVE DENTAL ISSURE COMPREHENSIVE DENTAL ISSURE COMPREHENSIVE dental that include dental care pain and infections, and maintenance of dental	W 356	The nursing staff will follow all dental polic and procedure to delitimely services to the individuals. See attachment #5	у	
	review, the facility fa treatment services f	s not met as evidenced by: on, interview and record ailed to ensure timely for the maintenance of dental se clients in the sample.				
	The finding includes	İ			ļ	!
į;	Observation of Clier revealed he had mis	nt #3 on 4/29/10, at 7:22 p.m., ssing teeth.	l į		ļ	

Event ID: BO9C11

Facility ID: 09G193

If continuation sheet Page 35 of 41

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/20/2010 FORM APPROVED OMB NO. 0938-0391

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILD	TIPLE CONSTRUCTION	(X3) DATE S	(X3) DATE SURVEY COMPLETED	
		09G193	B. WING		05/	3/2010	
NAME OF F	PROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE 74 W ST, NW WASHINGTON, DC 20015		3/2010	
(X4) IO PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE	
W 356	Interview with direct approximately 3:35 required encourage staff to ensure thore. Record review on 5 the following inform dental health during (a) 10/1/09 - The polient with severe gicalculus, and generand 15. Full mouth however, the period caries be addressed (b) 11/23/09 - The Client #3's annual of diagnosed large depon most teeth surfathere was no mention (c) 2/3/10 - The period (d) 4/7/10 - The period (d)	t care staff on 5/3/10, at p.m. revealed Client #3 ment and assistance from ough tooth brushing. /3/10, at 4:07 p.m., revealed ation regarding Client #3's consultations: eriodontist diagnosed the ingivitis, heavy plaque and calized caries of teeth #s 4,12, scaling was performed, lontist recommended that the d by a general dentist. general dentist conducted ral examination and posits of plaque and calculus ces. At that time, however, oning of any dental caries. riodontist again noted, to be addressed by general dentist for dentist for	W 35	6			
W 362	that the Client #3's operiodontist on 10/1. 483,460(j)(1) DRUG A pharmacist with in	rvey, there was no evidence caries identified by the /09 had been addressed. REGIMEN REVIEW put from the interdisciplinary e drug regimen of each client	W 362	MarJul Homes contracted pharmaci will review all individuals drug reg each quarter.			

DEPAR CENTE	TMENT OF HEALTH	AND HUMAN SERVICES & MEDICAID SERVICES				FORM	05/20/2010 APPROVED
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	LULTIPLE	CONSTRUCTION	(X3) DATE S	
·		09G193	B. WII	VG		084	2/2040
WESTVI	PROVIDER OR SUPPLIER EW 02			74 W	ADDRESS, CITY, STATE, ZIP CODE 7 ST, NW HINGTON, DC 20015	1 03/0	03/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	ix i	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CRDSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
W 362	Continued From pa	ge 36	W	362			
	Based on staff inter	s not met as evidenced by: view and record review, the ure consisterit quarterly drug three of the three clients in #3, #4, and #5]					
	The findings include): 					!
	4/29/10, at 6:19 p.m administered Rispe On the same date a administered Lipitor 50 mg/5 ml, 10 mls	medication administration on 1., revealed Client #4 was roll 3 mg and Geodon 20 mg. It 7:22 p.m., Client #3 was 20 mg and Docusate Sodium . At 6:35 p.m., on that evening inistered Tegretol 200 mg and a mouth.					
	p.m., and 2:05 p.m. most recent drug re	/30/10, at 2:35 p.m., 2:45 respectively, revealed the gimen reviews on file for #5 was signed and dated					
	on the same day at	cility's Registered Nurse (RN) 2:45 p.m. confirmed there egimen review on file for #5.					
W 460	had been conducted required.	rvey, there was no evidence red that drug regimen reviews at least quarterly, as					
** 700	483.480(a)(1) FOOE SERVICES	AND NO IKITION	W 4	60			
	Each client must red well-balanced diet in	eive a nourishing		1			

specially-prescribed diets.

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/20/2010 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER WESTVIEW 02 IN MIND STREET ADDRESS, CITY, STATE, ZIP CODE (XA) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REQUIATORY ON LSC DENTIFYING NEOMATION). PREFIX TAG W 460 Continued From page 37 W 460 Continued From page 37 This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility falled to ensure the therapeutic click was provided as prescribed for one of three in the sample. (Client #3) The finding includes: 1. The primary care physician (PCP) and the facility nutritionist failed to ensure timely monitoring of Client #3's constipation, as evidenced below. (a) On 4/30/10 at 8:30 p.m., the review of an (UIR) dated 9/14/09, revealed at approximately (10), and the client was readmitted to the hospital with a diagnosis of small bowel obstruction. A low residue diet was prescribed at discharge and the client was readmitted to the hospital with a diagnosis of small bowel obstruction. A low residue diet was prescribed at discharge and the client would receive follow-up by the PCP and the nutritionist. Continued record review on 5/3/10 at approximately 4:00 p.m. revealed a "readmission nutrition report" dated 10/12/09, byto weeks after Client #3's return to the home. The report acknowledged the client's hospital diagnosis of constipation and recommended to discontinue previous diet and to provide a low residue diet with Ensure Wice daily, it also noted that 8 glasses of water daily should be encouraged and recommended that a physical therapy consult be conducted for a possible exercise program. There		FATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1		LE CONSTRUCTION		TE SURVEY MPLETED
NAME OF PROVIDER OR SUPPLIER WESTVIEW 02 SIRRET ADDRESS, GITY, STATE, JIP CODE								
WESTVIEW 02 A W 31, M			09G193	B. WI	NG			5/03/2010
PREFIX TAG REQUIATORY OR LSC IDENTIFYING INFORMATION) W 460 Continued From page 37 This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure the therapeutic diet was provided as prescribed for one of three in the sample. (Client #3) The finding includes: 1. The primary care physician (PCP) and the facility nutritionist failed to ensure timely monitoring of Client #3's constipation, as evidenced below: (a) On 4/30/10 at 8:30 p.m., the review of an (UIR) dated 9/14/09, revealed at approximately 8.45 p.m., Client #3 was admitted to the hospital with a diagnosis of small bowled obstruction. A low residue deit was prescribed at discharge and the client was readmitted to the hospital with a diagnosis of small bowled obstruction. A low residue deit was prescribed at discharge and the client would receive follow-up by the PCP and the nutritionist. Continued record review on 5/3/10 at approximately 4:00 p.m. revealed a "readmission nutrition report" dated 10/12/09, two weeks after Client #3's return to the home. The report acknowledged the client's hospital diagnosis of constipation and recommended that a physical therapy consult be conducted for a possible exercise program. There					74	'W' ST, NW		
This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility falled to ensure the therapeutic diet was provided as prescribed for one of three in the sample. (Client #3) The finding includes: 1. The primary care physician (PCP) and the facility nutritionist failed to ensure timely monitoring of Client #3's constipation, as evidenced below. (a) On 4/30/10 at 8:30 p.m., the review of an (UIR) dated 9/14/09, revealed at approximately 8.45 p.m., Client #3's was admitted to the hospital with a diagnosis of small bowel obstruction. A low residue diet was prescribed at discharge and the client was readmitted to his group home on 9/24/09. A registered nurse (RN) coordinator progress note dated 4/5/20/10, documented the client would receive follow-up by the PCP and the nutritionist. Continued record review on 5/3/10 at approximately 4:00 p.m. revealed a "readmission nutrition report" dated 10/12/09, two weeks after Client #3's return to the home. The report acknowledged the client's hospital diagnosis of constipation and recommended to discontinue previous diet and to provide a low residue diet with Ensure brice daily, it also noted that 8 glasses of water daily should be encouraged and recommended that a physical therapy consult be conducted for a possible exercise program. There	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP	OULD BE	
was no evidence, however, that the nutritional assessment had been conducted timely or	W 460	This STANDARD is Based on observation review, the facility for diet was provided a in the sample. (Clie The finding includes 1. The primary care facility nutritionist farmonitoring of Client evidenced below: (a) On 4/30/10 at 8 (UIR) dated 9/14/08 8:45 p.m., Client #3 with a diagnosis of low residue diet was the client was read 9/24/09. A register progress note date client would receive nutritionist. Continued record reapproximately 4:00 nutrition report date client #3's return to acknowledged the constipation and reprevious diet and to with Ensure twice diglasses of water date conducted for a powas no evidence, he	s not met as evidenced by: ion, interview and record ailed to ensure the therapeutic is prescribed for one of three ant #3) s: e physician (PCP) and the ailed to ensure timely it #3's constipation, as :30 p.m., the review of an equipper in the proximately was admitted to the hospital small bowel obstruction. A is prescribed at discharge and mitted to his group home on ed nurse (RN) coordinator it 4/5/2010, documented the end follow-up by the PCP and the eview on 5/3/10 at p.m. revealed a "readmission and 10/12/09, two weeks after of the home. The report client's hospital diagnosis of commended to discontinue of provide a low residue diet laily. It also noted that 8 aily should be encouraged and a physical therapy consult be ssible exercise program. There lowever, that the nutritional	W	460	MarJul Homes will follow through on all nutritional concerns verthe agency's nutrition policy. See attachmen		

31 MIEMEN	I OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	Om *** =	PM - A	OMB NO	M APPROVI 0. 0938-03
AAD LEAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	PLE CONSTRUCTION	(X3) DATE	
	•					
NAME OF F	ROVIDER OR SUPPLIER	09G193	B. WING _		j os	03/2010
			STR	EET ADDRESS, CITY, STATE, ZIP COL		03/2010
WESTVI	EW 02		7/	4 'W' ST, NW)C	
(X4) ID	SI IAMADY OT		W	ASHINGTON, DC 20015		
PRÉFIX TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION I CROSS-REFERENCED TO THE A DEFICIENCY)	PUALIC AF	(X5) COMPLETIO DATE
W 460	Continued From pa	ige 38	184 400			
	assessed the feasil the client's irregular	bility of using foods to improve	W 460;			
ļ	Add 15/0/02 00 4/	n unusual incident report (UIR) 30/10, at 8:30 p.m., revealed				!
ļ	August 1946 Cak Bu	I IO MA AMAMAMAN MAN /EO	ļ			ŀ
İ	ivi dii evalualion (ii.	IR TO BO BOWE MANAGEMENT AND A	!			
	instructions reveale	2/9/09 ER discharge d a primary diagnosis of				!
	han Landoniliusi dei	neralized and a secondary	ļ			
!	ulagricals of Constit	Dation - uneparified The				!
i i	arreivale Ilisifuction	SIMMeted not seemble	:			
	possible cause of th	nd liquids in the diet as a	Ì			
	Recommendations in 10 -12 cups of fluids	BCluded a high Shor disk and	!			1
	On 5/3/10, at approx	kimately 4:10 p.m., review of Note, dated 12/29/09				l i
ļ	ravealed file bost bo	SDItal nutrition follows an	i			
, '	a. ooungeten milli i	DIRE WORKS later This				
11	assessment docume	ented that the client was a	i			
į,	recommendation to	iber diet. It further included a discontinue the low residue				
1.	aier implement a urc	In finer diet and to				
	er courage fluios da	IV No specific includions	!			
. •	ANGLE IUCITU	390 On how much & date			, İ	
	nad coordinated with	no evidence there the PCP nutritionist to ensure that the	1		ļ	
"	client's constipation verifiectively.	was addressed timely and	!			
12	2. The facility failed to	O ensure that menus	i			
2. The facility failed to ensure that menus were adjusted to accommodate the high fiber diet,				. i		
•	nechanical soft reco evidenced below:	mmended for Client #3, as			l I	
!		, 	ĺ			
ļ d	On 4/30/10, at 10:37 ated 4/5/10, at 9:15	a.m., the review of an UIR p.m., revealed Client #3 was	ļ 		ļ	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/20/2010 FORM APPROVED OMB NO. 0938-0391

	FOF DEFICIENCIES OF CORRECTION	(X1) PRDVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	IULTIP	PLE CONSTRUCTION	(X3) DATE S COMPLE	
		09G193	B. Wi	NG		05/0	3/2010
WESTVI	ROVIDER OR SUPPLIER			74	EET ADDRESS, CITY, STATE, ZIP CODE W ST, NW ASHINGTON, DC 20015		5/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX (EACH CORRECTIVE ACTION		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W 460	and treated for cor the UIRs revealed client returned to the On 5/3/10 at appropriate of the "nutrition assistant" and the appropriate of the "nutrition assistant" approximately was "follow-up nutrition dily." At that time juice twice daily was instructions, however much fluids to give Continued record rapproximately 4:35 "follow-up nutrition 4/29/10. According was "having difficu	nere he was diagnosed with, instipation. Continued review of on 4/6/10, at 10:30 p.m., the ne ER due to vomiting. Eximately 4:25 p.m., the review sessment quarterly note" dated Individual continues to suffer Diet appropriate to overall introgen (BUN) slightly high, issue. Will encourage fluids a high fiber diet with prune as recommended. No specific ver, were included on how daily. Teview on the same day at 5 p.m. revealed Client #3's assessment" was dated to the assessment, the client lty swallowing regular	W	460	DEFICIENCY		
ļ	consistency. Individual holds food in mouth, takes a very long time swallowing. Individual will be able to tolerate a mechanical soft diet. Will notify SLP (speech and language) for screening." At the time of the survey. however, the SLP screening had not been scheduled. Review of the menus on 4/30/10 at 9:30 a.m. revealed a single menu for all clients. Interview with the nutritionist on 4/30/10 at 10:39 a.m. revealed that the menus were "Heart Healthy" and should be appropriate for all clients in the facility. Interview with staff on 5/3/10, at 4:40 p.m., revealed that the client's food was cut to bite size and that he could chew it finely, but it took him a long time.						
	On 5/3/10 at 5:05 p	.m., review of menus available		1			

TATEMEN	RS FOR MEDICAR T OF DEFICIENCIES	E & MEDICAID SERVICES	···		FOR OMB N	M APPRO 0. 0938-0
ND PLAN (OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE	
		09G193	B. WING			
	PROVIDER OR SUPPLIER		STRE	ET ADDRESS, CITY, STATE, ZIP CODE	1 05/	03/2010
WESTVI			74	"W" ST, NW ASHINGTON, DC 20015		
(X4) ID PREF(X TAG	(EAGH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP	All Dec	(X5) COMPLE DATE
W 460	at the group home revealed they faile for staff on how to high fiber diet. For menu for Client #3 mechanical soft - 6 meats."	of or 4/2010 and 5/2010 d to provide specific guidelines prepare a mechanically soft or example, a note on the 5/2010 stated only "high fiber, extra fruits/vegetables, chopped in the first have a stated only "high fiber, extra fruits/vegetables, chopped in the first have a stated only "high fiber, extra fruits/vegetables, chopped in the first have a stated only "high fiber, excepted first have a stated first	W 460	DEFICIENCY	- ROTRIALE	
	(02-99) Previous Versions				į	

Event ID: BO9C11

Facility ID: 09G193

If continuation sheet Page 41 of 41

DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING HFD03-0202 05/03/2010 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **WESTVIEW 02** WASHINGTON, DC 20015 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) R 000, INITIAL COMMENTS R 000 A monitoring visit was conducted on 4/29/10, 4/30/10, and 5/3/10. A random sampling of three residents was selected from a resident population of three men and two females with various disabilities. The findings of the survey were based on observations, interviews with residents and staff in the home, as well as a review of resident and administrative records, including incident reports. The outcome of the survey determined that the facility was not compliance with 22 DC Municipal Regulations, Chapter 3500, Group Homes for the Mentally Retarded, as evidenced in the report that follows. R 125 4701.5 BACKGROUND CHECK REQUIREMENT R 125 The criminal background check shall disclose the The governing body will criminal history of the prospective employee or ensure that all staff have contract worker for the previous seven (7) years, in all jurisdictions within which the prospective provided the agency with employee or contract worker has worked or their background checks resided within the seven (7) years prior to the for all jurisdictions check. where they have either This Statute is not met as evidenced by: worked or lived in the Based on record review and staff interview, the past seven years. facility failed to ensure all criminal background checks covered where the employee worked or lived over the past seven (7) years as required by this section. [Staff #2 and #3] The finding includes: Interview with the facility's House Manager (HM) on 4/29/10 at approximately 12:10 p.m. revealed the facility has hired four new staff since 12/2009. Health Regulation Administration xecutive 100000 ellia DV LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVES SIGNATURE 6-7-2010

BO9C11

Health Regulation Administration

STATE FORM

ND PLAN	ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTII A. BUILDING	PLE CONSTRUCTION 3	(X3) DATE COMP	SURVEY LETED
		HFD03-0202		B. WING _	- [.		
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS CITY S	TATE, ZIP CODE	05/	03/2010
WESTVI	EW 02		74 'W' ST.	NW TON, DC 20			
(X4) ID PREFIX TAG	CONTRACTOR DEPICTENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY LSC IDENTIFYING INFORMA		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLI
R 125	Continued From pa	age 1		R 125	DEFICIENCY	1	
	conducted in all an	of the four newly hired staff, two of the criminal ackground checks falled to reflect a search was conducted in all areas where they either worked relived over the past seven years as evidenced elow:					
	1. Record review on 4/29/10, at approximately 12:20 p.m., revealed, Staff #2's job application listed hlm as either having worked or lived in the states of West Virginia and Pennsylvania within the past seven years. The criminal background check on record at the time of survey only covered the surrounding states of Maryland, Virginia and the District of Columbia.		ication d in the within Fround				
	listed him as either state of Florida with criminal background	v on 4/29/10, at approad, Staff #2 's job appli having worked or lived in the past seven year d check on record at the red the District of Colu	ication if in the is. The				
; 	Further interview with the facility's HM on the same day at approximately 2:25 p.m. revealed, she was not sure if the qualified mental retardation professional (QMRP) for the home had additional "new hire" information on these staff to address this oversight.					į	
There was no evidence on file at the time of survey to substantiate that all criminal background checks were conducted to cover the seven year requirement as cited above.							
						!	
1	Regulation Administration					1	

	TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU HFD03-0202		(X2) MULTIF A. BUILDING B. WING	LE CONSTRUCTION	(X3) DATE S COMPL		
NAME OF P	ROVIDER OR SUPPLIER			DDRESS, CITY, S	TATE, ZIP CODE		10	
WESTVIE	W 02		74 'W' S' WASHIN	ST, NW NGTON, DC 20015				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENT	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
1 000	INITIAL COMMEN	TS		1 000			†*************************************	
	4/30/10, and 5/3/10 residents was selected for three men and to disabilities. The fine on observations, in staff in the home, a and administrative reports. The outco that the facility was Municipal Regulation	vas conducted on 4/2). A random samplincted from a resident wo women with variodings of the survey waterviews with resider as well as a review of records, including interest the survey detend to compliance with ons, Chapter 3500, Contally Retarded, as evillows.	g of three population us /ere based hts and f resident cident /ermined 22 DC Group					
l 180	3508.1 ADMINISTS Each GHMRP shall			I 180				
ļ	administrative supp	port to efficiently mee ents as required by th	et the neir		See W252 and V	W159		
	Based on observat review, the GHMRP failed to e retardation profess integrated and mon	met as evidenced by ion, staff interview ar nsure that the qualificational (QMRP) coordinatored services for thing in the facility. Res	nd record ed mental nated, aree of the	1				
! 	The findings include	e:						
	The findings include	0 :						
,	documentation of p	RP failed to ensure (rogress on the Indivi) objective for Reside]	dual	**			<u> </u> 	
alth Regula	tion Administration		A	1 -tc = 1	1.		<u> </u>	
BORATORY	DUNECTOR'S OR PROVIDE	TWAIN DER <i>I</i> SUPPLIER REPRESEN	CAC ITATIVE'S SIG	POULUL A	Livetor TITLE	/	(X8) DATE -7-20	

Health I	Regulation Administra	ation	•			FORM	APPROVED
STATEMEN AND PLAN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE	R/CLIA MBER:	(X2) MUL A. BUILD B. WING		(X3) DATE SURVEY COMPLETED	
NAME OF I	ROVIDER OR SUPPLIER	HFD03-0202				05/	03/2010
l					, STATE, ZIP CODE		30,20,0
WESTVI				, NW STON, DC	20015		
(X4) ID PREFIX TAG	CAUH UEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA	e**	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHO (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	MADDE	(X5) COMPLETE DATE
I 180	Continued From pa	ge 1		1180			
	2. The facility's QMI services to ensure r	RP failed to coordina menus were modified a the prescribed dist	loe	. 100			
	services to ensure	RP failed to coordina quarterly drug regime cted for Residents #	an .		•		
1 204	3509.4 PERSONNE	EL POLICIES		1 204			
!	beginning of employ	ment.			The Human Resources Department at MarJul Homes will ensure that		
i	This Statute is not r Based on staff inten- Group Home for the (GHMRP) failed to e job description to re- employment for four [Staffs #1, #2, #3, ar	nsure all staff was pr /iew and sign at the t of four newly hired s	w, the erson(s) ovided a		policy and procedures with regards to person records and staff traini will be followed.	nel	
!	The finding includes:	:					
	Interview with the fac on 4/29/10, at appro- the facility has hired	KiMately 12:10 n m	muca ala d				
·	Record review on the 1:15 p.m. revealed, n reviewed showed evi description.	1000 of the four eleft.	*****			ļ	
! ;	The GHMRP failed to provided a copy of the and review prior to er his section.	elf lob description to	eion			 	
alth Regulat	ion Administration					i i	

STATE FORM

Health Regulation Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING HFD03-0202 05/03/2010 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 74 'W' ST, NW **WESTVIEW 02** WASHINGTON, DC 20015 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DATE DEFICIENCY) 1207 Continued From page 2 1207 1207, 3509.7 PERSONNEL POLICIES 1 207 See I204 A new employee 's physical examination shall have been performed within ninety (90) days prior to employment. This Statute is not met as evidenced by: Based on staff interview and record review, the Group Home for the Mentally Retarded Person(s) (GHMRP) failed to ensure all staff completed a physical examination at least ninety (90) days prior to their start of employment. [Staff #1, #2] #3, and #4] The finding includes: Interview with the facility 's House Manager (HM) on 4/29/10, at approximately 12:10 p.m., revealed the facility has hired four new staff since 12/2009. Record review on the same day at approximately 12:45 p.m. revealed, none of the four staff records reviewed showed evidence of a physical examination. Further interview with the facility's House Manager (HM) on 4/29/10 at approximately 1:05 p.m. revealed the additional personnel records may be with the Qualified Mental Retardation Professional (QMRP) because what she presented to the survey team was all that was on file at the time. The GHMRP failed to ensure all staff completed a physical examination prior to employment as required by this section. 1221 3510.2 STAFF TRAINING 1221

ND PLAN	NT OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU	er/Clia MBER:	(X2) MULTI A. BUILDIN B. WING	PLE CONSTRUCTION G	(X3) DATE COMPI		
AME OF F	PROVIDER OR SUPPLIER	1 111 503-0202	STREET AD	DDF00 cime	05/	03/2010		
WESTVI			74 'W' ST,	EET ADDRESS, CITY, STATE, ZIP CODE W ST, NW SHINGTON, DC 20015				
(X4) ID PREFIX TAG	(EACH DELIGIENC	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY LSC IDENTIFYING INFORMA	S	ID PREFIX TAG	PROVIDER'S PLAN OF C IEACH CORRECTIVE ACTK CROSS-REFERENCED TO TH	ON SHOULD BE IE APPROPRIATE	(X5) COMPLE DATE	
1221	1221 Continued From page 3			1204	DEFICIENCY) ————————————————————————————————————		
	Orientation training	shall be the respons	ibility of in each	1221	See I204		: 	
ļ	This Statute is not met as evidenced by: Based on staff interview and record review, the Group Home for the Mentally Retarded Person(s) (GHMRP) failed to provide orientation training for four of the four newly hired staff. [Staff #1, #2, #3, and #4]							
The finding includes:								
	OI 4/25/10, at appr	Interview with the facility 's House Manager (HM) on 4/29/10, at approximately 12:10 p.m., revealed the facility has hired four new staff since 12/2009.						
	TE OU P.III. TEVESIED	ne same day at appro I, none of the four sta nowed evidence of or	# i					
ļ	she was not sure if i	th the facility 's HM o imately 1:00 p.m. rev the training records to kept at the main offic	ealed,					
	survey to substantia	nce on file at the time te that all new staff re is required by this sec	accined					
1 223	3510.4 STAFF TRAI	NING		1223		; 		
	Each training program agenda and record of staff participation shall be maintained in the GHMRP and available for review by regulatory agencies.				See I204			
	This Statute is not m Based on staff interv Mentally Retarded Po Ion Administration	iew, the Group Home	for the			! 		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING HFD03-0202 05/03/2010 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CDDE 74 'W' ST, NW **WESTVIEW 02** WASHINGTON, DC 20015 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN DF CORRECTION (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) 1 223 Continued From page 4 1223 ensure all training records were made available at the time of survey. The finding includes: [Cross Reference 3510.2] Interview with the facility 's House Manager (HM) on 4/29/10, at approximately 1:00 p.m., verified all the training records for the four newly hired staff were not available for review. She further indicated that the additional training sheets may be with the Qualified Mental Retardation Professional (QMRP) because what she presented to the survey team was all that was on file at the time. The GHMRP failed to provide all training agenda and record of staff participation to the survey team as required by this section. 1227 3510.5(d) STAFF TRAINING 1227 Each training program shall include, but not be limited to the following: (d) Emergency procedures including first aid. See I204 cardiopulmonary resuscitation (OPR), the Heimlich maneuver, disaster plans and fire evacuation plans: This Statute is not met as evidenced by: Based on record review and staff interview, the Group Home for the Mentally Retarded Person(s) (GHMRP) failed to ensure all staff completed training in performing first aid and CPR. [Staff #1, #2, #3, and #41 The finding includes:

Health Regulation Administration

Health [Regulation Administra	<u>ation</u>				FORM	APPROVED
STATEMEN	IT OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI	R/CLIA MBER:	(X2) MUL A. BUILD B. WING		(X3) DATE COMPI	
NAME OF F	PROVIDER OR SUPPLIER	111 203-0202	STREET AD	2222		05/	03/2010
WESTVI			74 W ST		STATE, ZIP CODE 20015		
(X4) ID PREFIX TAG	(EACH DEHICIENCY	NTEMENT OF DEFICIENCIE: MUST BE PRECEDED BY SC IDENTIFYING INFORMA	Et it t	PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO) CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
l 227	Continued From pa	ge 5		1 227			<u> </u>
	the facility has hired Record review on the 12:55 p.m. revealed records reviewed shaid or CPR training. The GHMRP failed	to ensure all staff rec	revealed 12/2009. eximately off ther first	, <u></u> .			
1 374	3519.5 EMERGENO			1374			
; 	After medical service GHMRP shall promp guardian, his or her no guardian, or the responsoring agency coon as possible, foldocumentation no la after the incident.	Duy notify the residen next of kin if the resident representative of the of the resident's stat llowed by written notice	t's dent has us as		See W156		
	This Statute is not n Based on interview a GHMRP failed to pro guardian, his or her r services were secure and documentation n the incident, for two of GHMRP. (Residents	and record review, the mostly notify the residnext of kin after medied, followed by written to later than 48 hours of five residents in the	ent's cal notice				
-	The findings include:	•				ļ	
į	On 4/29/10, at approximate direct care staff is 2 both had legal gua heir habilitation and con Administration	revealed Residents#	4			 	

B09C11

Health Regulation Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING HFD03-0202 05/03/2010 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 74 'W' ST, NW **WESTVIEW 02** WASHINGTON, DC 20015 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DATE DEFICIENCY) 1374 | Continued From page 6 1374 Review of the GHMRP's incident reports and corresponding investigations on 4/30/10, beginning at 6:52 p.m., and on 5/3/10, at approximately 1:40 p.m., revealed the GHMRP failed to provide evidence that legal guardians and/or involved family members of Residents #1 and #2 were made aware of the following incidents: 1. An incident/investigation report (injury of unknown origin) dated 2/8/10, revealed that Resident #1 complained to staff that his neck was bothering him. 2. An incident report dated 11/8/09, and corresponding investigation report dated 11/10/09, revealed an allegation of sexual abuse. Resident #1 reported to staff that another staff had put his hands down his pants. 3. An incident report dated 9/26/09, and corresponding investigation report, revealed an allegation of verbal/physical abuse. Resident #2 came into the qualified mental retardation professional's (QMRP's) office and stated that a "counselor" told him to shut up" and pushed him off the van. 4. An unusual incident report dated 10/2/09, and corresponding investigation report dated 10/13/09, revealed an allegation of verbal abuse. While in court, Resident #2 kept raising his hand to speak. The judge allowed him to speak, and the resident stated "staff was hollening at him". At the time of the survey, the GHMRP failed to provide evidence that the legal guardians and/or involved family members of Residents #1 and #2 were made aware of the aforementioned

Health F	Regulation Administr	ation			•	FORM	APPROVED
STATEMEN AND PLAN	IT OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU	ER/CLIA MBER:	(X2) MUL A. BUILD B. WING		(X3) DATE:	
NAME OF F	ROVIDER OR SUPPLIER	111 500-0202	STREET AS	200500 000		05/0	03/2010
WESTVI	EW 02		74 'W' ST WASHING		, STATE, ZIP CODE 20015		
(X4) ID PREFIX TAG	LEACH DEFICIENCY	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	C* 11 1	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULDE	(X5) COMPLETE DATE
1 374	Continued From pa	ige 7		1374	1 10121017		
	incidents.			13/4			
I 379	3519.10 EMERGENCIES		1 379			 	
	In addition to the reporting requirement in 3519.5, each GHMRP shall notify the Department of Health, Health Facilities Division of any other unusual incident or event which substantially interferes with a resident's health, welfare, living arrangement, well being or in any other way places the resident at risk. Such notification shall be made by telephone immediately and shall be followed up by written notification within twenty-four (24) hours or the next work day.				See W156		
	dased on interview: and investigations, to mentally retarded per notify the Department Regulation and Lice of unusual incidents interferred with the re living arrangements, way places the resident shall be made by teles hall be followed up	nsing Administration or events which sub- esident's health, well well-being or in any lent at risk. Such noti ephone immediately by written notification or the next work dients in the GHMPP	nt reports ne ed to (HRLA) stantially fare, other ification and				
j.	The findings include:		ĺ			į	
	voiresponding invest	RP's incident reports a ligative reports on 4/3 n., revealed the follow	20/10 L			 	
	. An incident report	(injury of unknown o	origin)			į	
ıaπı Regulat	on Administration						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED. A BUILDING B. WING HFD03-0202 05/03/2010 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 74 'W' ST, NW **WESTVIEW 02** WASHINGTON, DC 20015 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) 1379 Continued From page 8 1379 dated 2/8/10, revealed that Resident #1 complained to staff that his neck was bothering him. The nurse was called and instructed the staff to escort the resident to the emergency room via the transportation van. The resident was discharged with a primary diagnosis of a "[strain] neck". Further review of the incident report, under the section of "verification notification? revealed that the nurse and house manager were the only staff informed of the injury of unknown origin. Interview with the QMRP on 4/30/10, at approximately 7:15 p.m., revealed that he and the administrator were both informed of Resident #1's injury of unknown origin on 2/8/10. However, there was no documented evidence that the administrator was immediately notified of Resident #1's injury of unknown origin. 2. An incident report dated 11/8/09, and corresponding investigation report dated 11/10/09, revealed an allegation of sexual abuse. Resident #1 reported to staff that another staff had put his hands down his pants. The nurse examined the resident for any signs of abuse Further review of the incident report revealed that the administrator was not informed of this allegation until 11/10/09, two days after the allegation was made. Interview with the previous Incident Management Coordinator on 5/3/10, at approximately 12:15 p.m., acknowledged that the administrator was not notified immediately of the allegation of sexual abuse until two (2) days later. 3. An incident report dated 9/26/09, and corresponding investigation report, revealed an allegation of verbal/physical abuse. Resident #2 came into the QMRP's office and stated that a "counselor" told him to shut up "and pushed him

Health Regulation Administration

BO9C11

STATEMEN AND PLAN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI	R/CLIA MBER:	(X2) MULTII A. BUILDING B. WING		(X3) DATE COMP	(X3) DATE SURVEY COMPLETED 05/03/2010	
NAME OF F	PROVIDER OR SUPPLIER	1 11 200-0202	STREET ADD	DEGG CITY of		05/		
WESTV!			74 W ST, WASHINGT	NW .	STATE, ZIP CODE			
(X4) ID PREFIX TAG	LEACH DEFICIENCY	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	Et 10 1	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLET	
1 379	off the van. The nuany signs of abuse, report revealed that informed of this alle QMRP on 4/30/10, acknowledged that notified immediately 4. An incident report corresponding investing 10/13/09, revealed a While in court, Resist to speak. The judge the resident stated "Further review of the the administrator was allegation. Interview with the Quapproximately 7:45 is	Further review of the the administrator was gation. Interview with at approximately 7:30 the administrator was of the allegation of a rt dated 10/2/09, and stigation report dated an allegation of verbadent #2 kept raising the allowed him to speal staff was hollering at the incident report reveas not informed of this of the p.m., acknowledged to the tight and the p.m., acknowledged to the tight and the p.m., acknowledged the training at the p.m., acknowledged the training at the training and the p.m., acknowledged to the tight and the p.m., acknowledged the training and the p.m., acknowledged the training at the p.m., acknowledged the training and the p.m., acknowledged the p.m., acknowledged the p.m.	sident for e incident as not h the O p.m., s not abuse. al abuse. his hand ak, and him". aled that	1 379				
	Professional service: and evaluation, inclu developmental jevels services, and service deterioration or furtheresident. This Statute is not make the development is not make the gradient is not make the gradient is services, the GHMRP is services included time.	s and needs, treatments designed to prever er loss of function by the designed to prevent net as evidenced by: n, interview, and reconstruction failed to ensure profectly diagnostic, evaluates to prevent deterior	ilagnosis nt nt the	401	See W318 and W1	56	 - - - - - - - - - - - - -	

STATE FORM

Health Regulation Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING **B. WING** HFD03-0202 05/03/2010 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 74 'W' ST, NW **WESTVIEW 02** WASHINGTON, DC 20015 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) 1401 | Continued From page 10 1401 The findings include: I. The GHMRP's nursing services failed to ensure services were provided in accordance with the needs of Residents #1, #2 and #3) as evidenced below: A. Timely monitoring and implementation of measures to minimize the frequency of emergency room visits for Resident #3 had not been provided timely. Interview with the residential staff on 4/30/10 at 8:49 a.m. revealed that Resident #3 had been hospitalized several times since the 6/25/09 survey. Interview with the home manager on 4/30/10 at approximately 9:40 am, revealed that the practice was that if the resident did not have a bowel movement within 2 to 3 days, the nurse was informed so that the resident received his pm medication for constipation. The home manager also indicated that that if the resident did not have a stool in 3 to 4 day, upon assessment by the nurse and instructions by the physician, the resident was to be taken to the ER for assessment. Interview with the recently hired registered nurse (RN) on 5/3/10 at approximately 7:40 p.m., however revealed that she had not seen a written policy stating when the resident should be taken to ER for constipation. Record review on 4/30/10 and on 5/3/10 confirmed the following ER visits/ hospitalization had occurred: (1) A "Further Evaluation /Services Request" from Resident #3's day program dated 9/14/09 (12:30 p.m.) revealed he was evaluated for his complaint of abdominal pain, holding his

Health I	Regulation Administra	ation				FORM	APPROVED
STATEMEN AND PLAN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU	R/CLIA MBER:	(X2) MULT A. BUILDIN B. WING		(X3) DATE SURVEY COMPLETED	
NAME OF I	PROVIDER OR SUPPLIER	NFD03-0202	OTDEET AS			05/0	3/2010
					STATE, ZIP CODE		
WESTVIEW 02 74 W ST WASHING		TON, DC 2	0015				
(X4) ID PREFIX TAG				(D PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
	abdomen tight and resident's abdomen distended. The resi x 3, to have faint bo .P76 R28. He apper on the commode for groaned, but could accordingly and more accordingly and more accordingly and more accordingly and more accordingly and more accordingly and more accordingly and more accordingly and more accordingly and more accordingly and more accordingly and more accordingly and accordingly and accordingly and accordingly and according according according according according to the according accordin	crying. Upon assess a appeared very hard dent was reported as evel sounds, BP 156 pared to be constipated and the pushed and not go. Please treat enitor closely. Dottom of the form with the form with relief. Laxast pushed. Vital signs distended without cossment. Ongoing assessment. Ongoing assessment, Resident #3 were stomach and compart was notified, and upructions by the RN., the dot of the hospital ER codomen confirmed a fine medical impressively related to adhesion. Small bowel obstructive therapy." A lot iet was prescribed. The ged back to his grounder ged back to his grounder ged back to his grounder.	and soriented /96, T97 ed - sat d ritten bym.) tive given were emplaint sessment ed at es laining of bon the for small on was ns. The tion, now w The up home	1401	DEFICIENCY		DATE .
	(2) The review of an 4/30,10 at 8:30 p.m. direct care staff (DC Resident #3 had no since 12/4/09. On thapproximately at 4:0	revealed that on 12/S) informed the nurs thad a bowel moven e next day (12/8/09)	7/09, a e that nent				

Health Regulation Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING HFD03-0202 05/03/2010 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 74 W'ST, NW **WESTVIEW 02** WASHINGTON, DC 20015 **SUMMARY STATEMENT OF DEFICIENCIES** (X4) ID PROVIDER'S PLAN OF CORRECTION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY 1401 Continued From page 12 401 the staff and stated that per the RN coordinator's instructions, the resident should be taken to the ER, if he did not have a BM. Upon review of the resident's record, it was was determined by the LPN an the Qualified Mental Retardation Professional (QMRP) that the resident should be taken to the ER for evaluation. On 4/30/10 at approximately 7:10 p.m., review of Residents #3's 12/9/09 ER discharge instructions revealed a primary diagnosis of pain-abdominal, generalized and a secondary diagnosis of Constipation - unspecified. Blood work and an acute abdomen series and a CT of abdomen and pelvis w/ contrast were performed stat due to the resident complaint of abdominal pain. The resident was discharged from the ER in satisfactory condition with a recommendation for follow-up by the primary care physician (PCP) in 1 - 2 days, without fail. (3) On 4/30/10 at 10:37 a.m., the review of an unusual incident report (UIR) dated 4/5/10 revealed that at 9:15 p.m. a direct care staff (DCS) discovered Resident #3 on the floor holding his side crying, and saying "I need to go to the hospital". According to the UIR, the supervisor was informed of the resident's complaint, then telephoned the registered nurse. Further review of the UIR revealed the R.N. instructed staff to escort the resident to the hospital. The resident was diagnosed with and treated for constipation, and then released to the group home. (4) On 4/30/10 at 4:45 p.m., the review of an UIR dated 4/6/10 revealed that at 10:30 p.m., a direct care staff observed Resident #3 standing at the main entrance of the facility. The UIR documented that the resident had vomited all

AND PLAN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUMBER OF THE PROVIDER OF	A. BUILDING			DATE SURVEY COMPLETED	
NAME OF I	PROVIDER OR SUPPLIER		STREET ADDRE			05/	03/2010
WESTVI			74 W'ST, N'WASHINGTO	W .	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(FACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY LSC IDENTIFYING INFORMA	3	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1	TON SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
	the emergency roo (5) On 4/30/10 at 1 was heard coming The home manage saying that Resider yelling. The manag was wrong with him determine the rease the home manager complained of stom wanted to go to the yelling had subside continued to whine. manager was observesident to the ER v Record review on 5. Record review on 5. Resident #3 was dis 5/1/09 and that his p constipation. B. The GHMRP's not coordinate services physician (PCP) and to determine the crit medication to preve as evidenced below Interview with staff f overnight shifts at va 5/3/10 revealed Res difficulty with regular staff indicated that the inform the nurse if the in two to three days, the resident's stools	R.N. was notified immif to take the resident to take the resident to the for further evaluation of for further evaluation of the form the front of the form the front of the form went to check, and on the far was the individual er commented that so the form the resident's year on for the resident's year discovered that the mach pain and said that hospital. By 10:42 and hospital by 10:42 and hospital by 10:42 and hospital by 10:42 and hospital by 10:42 and the preparing to sen with a DCS. If 3/10 at 10:40 a.m. rescharged from the ER primary diagnosis was the gastroenterological teria for administering and Resident #3's considerity and the gastroenterological teria for administering and Resident #3's considerity and the gastroenterological teria for administering and Resident #3's considerity and the gastroenterological terial for administering and Resident #3's considerity and the gastroenterological terial for administering and Resident #3's considerity and the gastroenterological terial for administering and Resident #3's considerity and the gastroenterological terial for administering and Resident #3's considerity and the gastroenterological terial for administering and Resident #3's considerity and the gastroenterological terial for administering and the gastroenterological terial for administering and the gastroenterological terial for administering and the gastroenterological terial for administering and the gastroenterological terial for administering and the gastroenterological terial for administering and the gastroenterological terial for administering and the gastroenterological terial for administering and the gastroenterological terial for administering and the gastroenterological terial for administering and the gastroenterological terial for administering and the gastroenterological terial for administering and the gastroenterological terial for administering and the gastroenterological terial for administering and the gastroenterological terial for administering and the gastroenterological terial	elling elling, esident at he m., the ent come d the vealed on sist (GI) the pm tipation and 0 and The ed to ve a BM ent that he m.	401	DEFICIENC	m)	

Health Regulation Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING HFD03-0202 05/03/2010 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 74 'W' ST, NW **WESTVIEW 02** WASHINGTON, DC 20015 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) I 401 Continued From page 14 1401 on 5/3/10 at approximately 11:35 a.m., for the 4/2010 confirmed the staff statements. Interview with the recently hired RN on 5/3/10 at approximately 7:40 p.m., however revealed she was hired by the agency on 4/8/10. The RN acknowledged that there had been several changes in the RN coverage at the GHMRP. The RN revealed that her review of Resident #3's record failed to identify instructions or a protocol on when the resident was to be given the prn medications (Constulose or Milk of Magnesia) for constipation. On 4/30/10 at 6:40 p.m., review of an RN progress note dated 10/22/09 written to the gastroenterologist (GI) revealed, "He was last hospitalized on 9/14/09 for bowel obstruction. He has had problems with regular bowel movements. His diet was changed from high fiber to low residue. The docusate sodium does not appear to keep him regular. Is there another medication he can take? Fluid intake is good. Hospitalized for GI Distress 6/7/09 and 9/14/09. The GI responded by prescribing Lactulose 30 ml po prn constination prn and to follow up in 2 months." On 4/30/10 at 6:55 p.m., review of a RN monthly progress summary dated 11/09 (for 10/09). indicated that the GI specialist had added a prolaxative to Resident #3's medication regimen. The staff are continually reeducated verbally regarding the need to follow closely. [The resident's] elimination pattern still erratic (every 3 days or 4 days), taking meds as directed. The nurse acknowledged the GI's order for Lactulose prn to assist in his GI issues.. and noted "Bowel movements noted every 3 - 4 days, Drs. are aware."

Health I	Regulation Administr	ation				FORM	APPROVED
STATEMEN AND PLAN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU. HFD03-0202	R/CLIA MBER;	(X2) MUL A. BUILDI B. WING		(X3) DATE (
NAME OF F	PROVIDER OR SUPPLIER		CTDEET .			05/0	03/2010
					, STATE, ZIP CODE		
WESTVI				TON, DC	20015		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
l 401	Continued From pa	ige 15		1401			
	Continued record re revealed the month and 12/09 document	eview on 5/3/10 at 11 ly nursing summaries nted an erratic stool p aving stools every thr	s for 1/09	, , , ,			
ļ	#3 should receive the review of the medic	hat although nursing) documented that Re ne Constulose 30 ml ation administration i sident had only recei	esident daily pm,				
-	At the time of the survey, there was no evidence nursing services had coordinated with the primary care physician and the gastrologist to obtain further instructions on when to administer the pm medication for constipation.					·	
 	4/29/10 at /:40 p.m.	of the medication sup and again on 7:50 p lose was available at	m				
ļ	IONOM-ND IDLIKESIDE	ed to ensure timely ment #3 after his emergonstipation, as evider	encu/				
	revealed that at 9:15 (DCS) discovered Rocrying. He was taken was diagnosed with "constipation -slow treturned to the emenassessment of yomit discharge summary	:37 a.m., the review of the control (UIR) dated 4/5/10 p.m., a direct care sesident # 3 on the floor to the ER for evalual pain -abdominal and ansit. The Resident gency room on 4/6/10 for the Edated 4/6/10 for the 4-4-10 with the primary of	taff or and stion and d t 0 for				

BO9C11

Health F	Regulation Administr	at <u>lon</u>				FORM	APPROVED
	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0202		R/CLIA MBER:	(X2) MULTI A BUILDING B, WING	PLE CONSTRUCTION	(X3) DATE S COMPL	ETED
NAME OF F	ROVIDER OR SUPPLIER	111 500-0202	STREET ADD	DESC CITY O	STATE, ZIP CODE	05/0	<u> </u>
	í				STATE, ZIP CODE		
WESTVI	EW 02		74 'W' ST, WASHING	TON, DC 20	0015		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
l 401	401 Continued From page 16			I 401			
	physician (PCP in two to four days" and to "contact the ER" if there was a problem arranging the follow visit with the PCP. A high fiber diet and more fluids were recommended.						
	p.m., revealed a a c primary care physic which stated that th	l/30/10, at approxima consultation report fro cian (PCP) dated 4/13 ne resident was evalu	om the 3/10, ated in				
	the ER for constipation and that the symptoms were now resolved. There was no evidence that the resident receive follow-up within the recommended time frame.		ence that				
	records revealed he every one to three of 4/24/10. Documen 4/24/10 and 4/30/10 the resident had an complaint of abdom	hat Resident #3's sto e continued to have hadays, between 4/13/1 tation of stools between 0, revealed no eviden y stools for six days. hinal pain, the resider on 4/30/10 and was o	nard stool 0 and een nce that Due to a				
	p.m. revealed Resider on 12/8/09 for a Residents #3's 12/9 revealed a primary generalized and a s Constipation - unsp summary included a follow-up by the primary 1 - 2 days, without f to document eviden	UIR dated 12/8/09 a dent #3 was evaluate constipation. Review of 8/09 ER discharge insidiagnosis of econdary diagnosis of ecified. The discharge a recommendation for mary care physician (ail. The resident recommendation for call and the PCP follo- days after his readmin	d at the of structions dominal, of ge or PCP) in ord failed w-up				
,	III. The GHMRP's paralled to ensure over	rimary care physiciar rsight of the medicati	(PCP) on and				1

STATEMENT OF DEFICIENCIES (X1) PROMIDED TO THE		T.						
AND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU	ER/CLIA MBER:		LTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
				A. BUILE		00.,,,,		
MANAGOG		HFD03-0202		B. WING		05/03/2010		
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CIT	Y, STATE, ZIP CODE	03/1	03/2010	
WESTV	EW 02		74 W ST WASHING	, NW STON, DC	20015			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIE	s	ID	SPONDER BY AND SECOND			
PREFIX TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	(EACH CORRECTIVE ACTION SHOULD BE COMPLE CROSS-REFERENCED TO THE APPROPRIATE DATE		
401	Continued From page 17			1401				
	diet prescribed for Resident #3 to prevent constipation as evidenced below:							
	During the medication	on administration						
	Observations on 4/2	!9/10.at7:28.nm ⊠	esident					
	ma/10 mi by mouth	ate sodium 50 mg/5 r The review of the 4	nl, 100					
	i pnysician's orders re	evealed the medicati	/1/10 On was					
	, prescribed as a stoc	ol softener			-			
	revealed a current	w on 5/3/10 at 10:45	a.m.,					
	revealed a current p Constulose 10 cm/1	onysician's order for 15 ml syrup, 30 ml by	marak				i l	
	dally, as needed for	Constination. The n	hveician'e					
	corders revealed that	t the Constulose was	initially		1			
į	prescribed on 10/23	V09 by the nastroant	arologica					
	and was subsequen Review of the medic	illy approved by the f	PCP.				! 	
	10/2009 revealed a	10/23/2009 order for	for				į [
<u> </u>	"Lactulose 30 ml po constipation."	daily as need for						
		imakal 7.45					!	
	On 5/3/10 at approxi	registered purso (Ch	lerview				!	
	revealed that it could	not be agreetained.	المعدأة				1 1	
!	when the resident m	lay have received the	. 1				!	
j	Constuiose other tha	an in 12/09. Continue	الما					
!	interview with the RN nurse (LPN) revealed	vand the licensed p	ractical				!	
ļ	available at the GHN	IRP.						
	On 5/3/10 at 10:35 a	.m., the review of the	,			į		
!	medication administr	ration record (MAR)	for 11/00	_				
ļ	revealed that MOM 1 evening was listed ar	i oz. PU as needed	in the				1	
	According to the 12/2	2009 MAR the residu	antura			ļ		
1	antituisteted COUSIN	IIOSE IN the evening o				I	İ	
	eleven days. Continu	ied review of the MA	Re from					
	10/2009 through 5/3/ documentation that R	Resident #3 was	į					
1	administered Constu	lose at any other time	e. It			;		
olth Damile	tion Administrative	7	""					

_Health Regulation Administration

Health Regulation Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A BUILDING B. WING HFD03-0202 05/03/2010 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 74 'W' ST, NW **WESTVIEW 02** WASHINGTON, DC 20015 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) 1401 Continued From page 18 1401 should be noted that the MAR documented the administration of MOM on 10/11/09 (for hard stool) and 10/14/09 (for no stool reported by staff). At the time of the survey, there was evidence medical criteria had been established to determine when to administer the Constulose and/or the prn. Additionally, there was no evidence effective preventive measures had been implemented to minimize Resident #3's risk of constipation. IV. The GHMRP's nursing services failed to ensure lost/missing medication was documented as evidenced below: Observation of the medication administration on 4/29/10 at 7:35 p.m., revealed that Resident #1 received Dilantin 50 mg tab (3 tabs), 150 mgs. The nurse was observed to punch the pills from the section of the card dated 4/30/10. Interview with the nurse at the time the medication was punched from the card revealed he did not know the reason the evening dosage of the Dilantin for 4/29/10 was missing. Further interview with the both the R.N. and the medication nurse on 4/29/10 indicated that a dosage of the Dilantin was already missing from the card when they began working for the agency, approximately 10 days prior to the survey. According to the nurses, if a resident's medication was lost for any reason, it should be documented in the resident's record, then reordered from the pharmacy. V. The GHMRP failed to ensure medication was administered without error for Resident #1 as evidenced below:

Health F	Regulation Administra	ation			·	FORM	APPROVED
STATEMEN AND PLAN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU	R/CLIA MBER:	(X2) MUL A. BUILD B. WING		(X3) DATE : COMPL	
NAME OF F	PROVIDER OR SUPPLIER	111003-0202	OYDEET 45	22-22-2-		05/0	03/2010
	WESTVIEW 02 74 W ST				7, STATE, ZIP CODE 20015		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTID CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE	
l 401	Continued From pa	ge 19	····	i 401		<u> </u>	
	was observed to ap cream to Resident a direct care staff info time to go to the sto 7:55 p.m., the reside the home with staff Interview with the m 7:36 p.m., indicated the Desonide Cream evening. Interview we retardation profession approximately 7:40 resident takes a should be review of the 4/4/29/10 at approximate approximate approximate approximate applied to his face a At the time of the su that the medication is	rvey, there was no e	0.05% m., a at it was nome. At turning to /10 at s to have in the ntal //10 at aled the bed. s on aled the				
,	#1 medication was a accordance with the	loblied to his face in	esident				
1	Vi. The GHMRP falls treatment services for dental caries as evid	or Resident #3 to add	ental dress his				
į I	Observation of Resk p.m. revealed he had	dent #3 on 4/29/10 at d missing teeth.	7:22				
	Interview with direct approximately 3:35 prequired encouragen staff to ensure thorou	o.m. revealed Reside	nt#3			<u> </u> 	
	Record review on 5/3	3/10 at 4:07 p.m. rev	ealed			ļ	

Health Regulation Administration STATEMENT OF DEFICIENCIES (X1) PRDVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING HFD03-0202 05/03/2010 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 74 'W' ST, NW **WESTVIEW 02** WASHINGTON, DC 20015 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (X5)(EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PRÉFIX PREFIX COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE DEFICIENCY) 1401 Continued From page 20 L401 the following information regarding Resident #3's dental health during consultations: 10/1/09 - (Follow-up periodontal treatment) Diagnosis: Severe gingivitis, heavy plaque and calculus, generalized caries of teeth #'s 4, 12, and 15. Full mouth scaling performed. Recommendations: (1) Assistance with tooth brushing; (2) Periodontal maintenance in 2 months: (3) Caries to be addressed by general dentist. 11/23/09 - (Annual oral examination) Diagnosis: Large deposits of plaque and calculus is present on most teeth surfaces. Recommendation: Return to this office for full mouth scaling and prophylaxis. Request for preauthorization to be made, and once it is obtained by the dentist. dentist will call group home to reschedule resident's appointment. 2/3/10 - (Follow-up cleaning/extraction) evaluation) Diagnosis: Gingivitis, heavy plaque and calculus, and generalized caries. Full mouth scaling performed. Recommendations: (1) Assistance with tooth brushing 3 x daily: (2) Periodontal maintenance in 2 months: (3) Generalized caries to be addressed by general dentist. 4/7/10 - (Follow-up periodontal treatment) Diagnosis: Generalized bleeding, improved hygiene, not as much plaque. Full mouth scaling performed. Recommendations: (1) Continue assistance with tooth brushing 3 x daily; (2) Periodontal maintenance in 2 months; (3) Needs appointment with general dentist for caries control. At the time of the survey, there was no evidence

BO9C11

Health (Regulation Administr	ation				FORM	APPROVED
STATEMEN AND PLAN	TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0202		R/CLIA MBER;	(X2) MUL A. BUILD B. WING		(X3) DATE:	SURVEY LETED
NAME OF F	PROVIDER OR SUPPLIER	11/1003-0202	OTDEET 40			05/0	03/2010
					, STATE, ZIP CODE		
WESTVI			74 'W' ST WASHING	TON, DC	20015		
(X4) ID PREFIX TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD DE	(X5) COMPLETE DATE
i 401	Continued From pa	ge 21		I 401			
	that the time of the survey, there was no evidence that Resident #3's caries identified by the periodontist on 10/1/09 and been filled and/pr addressed.						
j	VII. The GHMRP failed to ensure quarterly drug regimen reviews for were conducted timely for Resident #3, #4, and #5 as evidenced below:						
	A. Observation of the pass on 4/29/10, at #4 was administered 20 mg. Record revirevealed the most refile for Resident #4 to 1/6/2010. Consider review should have 4/6/2010. Interview Registered Nurse (Fp.m. confirmed there review on file for the	ew on 4/30/2010 at 2 event drug regimen r was signed and date ing this date, a follow been completed no I with the GHMRP's (N) on the same day a was no other drug.	Resident de Geodon 2:35 p.m. eview on de r-up ater than				
ļ 	B. Observation of the pass on 4/29/10, at 1/3 was administered Sodium 50 mg/5 mi, review on 4/30/2010 most recent drug reg Resident #3 was sig Considering this date have been complete Interview with the GM (RN) on the same dathere was no other d for the resident.	7:22 p.m., revealed F I Lipitor 20 mg and D 10 mels 5 mg. Reco at 6:45 p.m. reveale gimen review on file f ned and dated 1/6/20 a, a follow-up review d no later than 4/6/20 HMRP's Registered N ay at 2:45 p.m. confin	Resident cocusate ord d the or 010, should 010.				
j	C. Observation of the pass on April 29, 201 Resident #5 was admand Risperdal 0.5 mg	0, at 6:35 p.m., reve	aled			 	

Health Regulation Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A BUILDING B. WING_ HFD03-0202 05/03/2010 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 74 'W' ST. NW **WESTVIEW 02** WASHINGTON, DC 20015 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY 1 401 Continued From page 22 401 on 4/30/2010 at 2:05 p.m. revealed the most recent drug regimen review on file for Resident #5 was signed and dated 1/6/2010. Considering this date, a follow-up review should have been completed no later than 4/6/2010. Interview with the GHMRP's Registered Nurse (RN) on the same day at 2:45 p.m. confirmed there was no other drug regimen review on file for the resident. VIII. The GHMRP failed to ensure Resident #3's therapeutic diet was provided timely, as prescribed to address his health concern (constipation), as evidenced below: A. On 4/30/10 at 8:30 p.m., the review of an (UIR) dated 9/14/09 revealed at approximately 8:45 p.m., Resident #3 was admitted to the hospital with a diagnosis of small bowel obstruction. A low residue diet was prescribed at discharge and the resident was readmitted to his group home on 9/24/09. A registered nurse (RN) coordinator progress note dated 4/5/10 documented that the client would receive followup by the primary care physician and the nutritionist. Continued record review on 5/3/10 at approximately 4:00 p.m. revealed a "readmission nutrition report" was conducted on 10/12/09, two weeks after Resident #3's return to the home. The report acknowledged the resident's hospital diagnosis of constipation and recommended to discontinue previous diet and to provide a low residue diet with Ensure twice daily. It also noted that 8 glasses of water daily should be encouraged and recommended that a physical therapy consult be conducted for a possible exercise program. There was no evidence, however, that the nutritional assessment had

Health F	Regulation Administr	ation				FORM	APPROVED
STATEMEN AND PLAN	ATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMSER: HFD03-0202		ER/CLIA MSER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED	
NAME OF F	PROVIDER OR SUPPLIER	111 000-0202	CTREET AD	DRESS, CITY, STATE, ZIP CODE		05/0	03/2010
WESTVI			74 W ST				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
I 401	Continued From page 23 been conducted timely or assessed the feasibility of using foods to improve the resident's irregular bowel elimination.		I 401				
					•		
	B. The review of an UiR dated 12/8/09 on 4/30/10 at 8:30 p.m. revealed Resident #3 was taken to the ER for an evaluation due to no bowel						
ļ	movements for several days. The 12/9/09 ER discharge instructions revealed a primary diagnosis of pain-abdominal, generalized and a secondary diagnosis of Constipation -						
	unspecified. The a not enough rougha diet as a possible c	ftercare instruction s ge or fiber and liquid: ause of the constipat included a high fiber	s in the				
	revealed the post he conducted three we documented that the a high fiber diet. It for recommendation to diet and to impleme	dimately 4:10 p.m., re Note, dated 12/29/0 ospital nutrition followeks later. This assest resident would benurther included a discontinue the lower of a high fiber diet.	19 v-up was ssment efit from residue			,	
	constipation was ad	nsure that the resider dressed timely.	nts				
 	C. The GHMRP faik adjusted to accommanded for R below:	nodate the high fiber	diet			,	
	On 4/30/10 at 10:37 dated 4/5/10 at 9:15 was taken to the ER with, and treated for review of the UIRs rep.m., he returned to	p.m. revealed Resid where he was diagr constination. Contin	lent #3 losed ued				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING HFD03-0202 05/03/2010 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 74 'W' ST. NW **WESTVIEW 02** WASHINGTON, DC 20015 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (X5) COMPLETE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DATE DEFICIENCY) 1401 Continued From page 24 1401 On 5/3/10 at approximately 4:25 p.m., the review of the "nutrition assessment quarterly note" dated 4/13/10 revealed. "Individual continues to suffer from constipation. Diet appropriate to overail health. BUN slightly high, possible hydration issue. Will encourage flulds daily." At that time, a high fiber diet with prune juice twice daily was recommended. Continued record review on the same day at approximately 4:35 p.m. revealed Resident #3's "follow-up nutrition assessment" was dated 4/29/10. According to the assessment, the resident was "having difficulty swallowing regular consistency. Individual holds food in mouth, takes a very long time swallowing. Individual will be able to tolerate a mechanical soft diet. Will notify SLP (speech and language) for screening." Review of the menus on 4/30/10 at 9:30 a.m. revealed a single menu for all residents. Interview with the nutritionist on 4/30/10 at 10:39 a.m. revealed that the menus were "Heart Healthy" and should be appropriate for all residents in the GHMRP. Interview with staff on 5/3/10 at 4:40 p.m. revealed that the resident's food was cut to bite size and that he could chew it finely, but that it took him a long time. On 5/3/10 at 5:05 p.m., review of menus available at the group home for 4/2010 and 5/2010 revealed they failed to provide specific guidelines for staff on how to prepare a mechanically soft high fiber diet. [Note: Resident #3 returned to the ER on 4/30/10. The discharge summary dated 5/1/10, revealed that he was again diagnosed with constipation.] Health Regulation Administration

Health Regulation Administration

BO9C11

i legili i	equiation Administra	<u> </u>					
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI HFD03-0202	R/CLIA MBER:	(X2) MULT A. BUILDIN B. WING	PLE CONSTRUCTION	(X3) DATE S COMPL	ETED
NAME DE P	ROVIDER DR SUPPLIER	1 ПГО03-0202	OTDERT AN	DDESO OFFI		05/0	3/2010
WESTVI			74 W ST		STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA	S FIN:	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HDULD BE	(X5) COMPLETE DATE
1 407	Continued From page 25			I 407			<u> </u>
l 407	3520.9 PROFESSION SERVICES: GENERAL PROVISIONS Each GHMRP shall obtain from each professional service provider a written report at least quarterly for services provided during the preceding quarter.			1407	See W336		
	This Statute is not met as evidenced by: Based on record review and staff interview, the GHMRP failed to ensure quarterly nursing reviews and assessments were completed on a timely basis to maintain a resident's health and safety. [Residents #3, #4, and #5]						
	The findings include	e:	ļ				
	revealed the most r	on 4/30/10 at 6:35 p.r recent nursing quarte s signed and dated 1	riv on file				
; ; !	Interview with the GHMRP's registered nurse (RN) on the same day at approximately 7:15 p.m., confirmed no quarterly assessment was completed for the resident after 12/2009. Resident #4's last monthly nursing assessment was also dated 12/09. The record documented nursing progress notes every one to two weeks thereafter, until 4/10/10. The progress notes, however, failed to closely monitor the status of the resident's most pressing medical concern which was constipation.						
ļ						j	
 	At the time of the survey, the GHMRP failed to ensure the timely completion of nursing quarterly assessments to ensure Resident #3's health and safety.		quarterly 1				
-	Record review or revealed the most re-	n 4/30/10 at 2:08 p.m ecent nursing quarte	n. rly on file				<u> </u>

BO9C11

Health Regulation Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING HFD03-0202 05/03/2010 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 74 'W' ST. NW **WESTVIEW 02** WASHINGTON, DC 20015 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 1407 Continued From page 26 1407 for Resident #4 was signed and dated 9/2009. interview with the GHMRP's RN on the same day at approximately 2:50 p.m. confirmed there was no other quarterly assessment completed since 9/2009. In addition, she explained that whatever was in Resident #4's medical record was all that was available to review. The GHMRP failed to ensure the timely completion of nursing quarterly assessments to ensure Resident #4's health and safety. 3. On 4/30/10, at 1:42 p.m., review of the Resident #5's medical record revealed the most recent nursing quarterly on file was signed and dated 9/2009. Interview with the GHMRP's registered nurse (RN) on the same day at approximately 2:50 p.m., confirmed there was no other quarterly assessment completed since 9/2009. in addition, she explained that whatever was in Resident #5's medical record was all that was available to review. Health Regulation Administration